Canadian Hospital

- *Lethbridge Municipal Hospital*
- *Maritime hospital convention*
- *Battle against staphylococcus aureus*
- *Time and motion study—a challenge*

Canadian Hospital Association

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Contents

Vol. 33 JULY, 1956 No. 7

(For Subscription Rates, see page 94)

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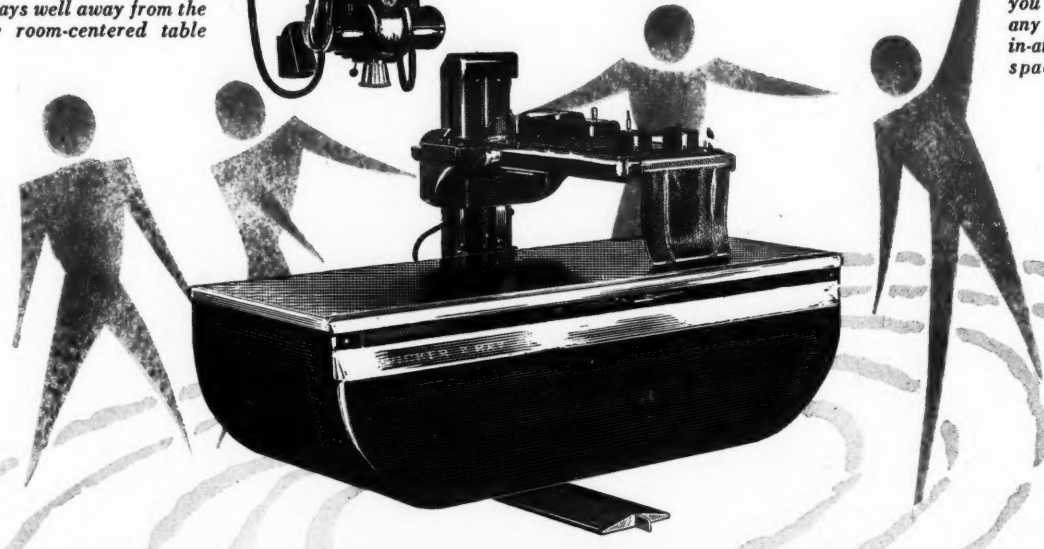

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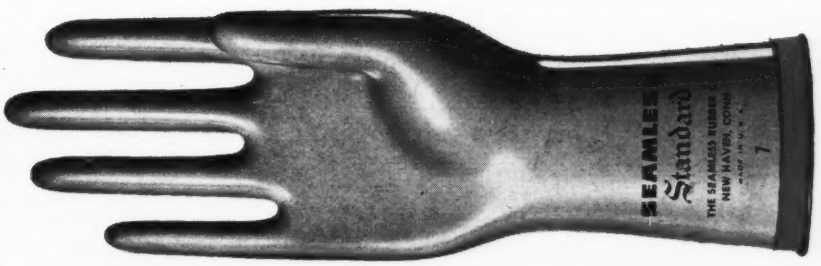

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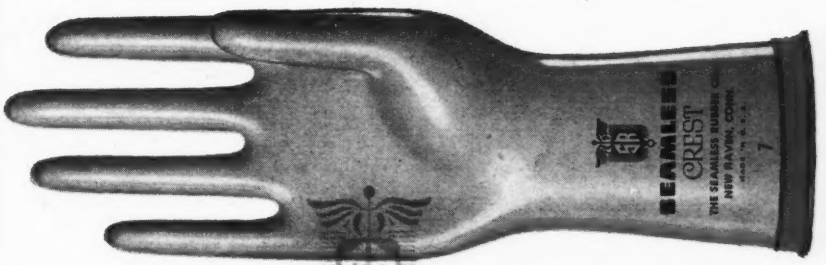

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◂ Notes About People ▸

Stanley W. Martin,
Executive Secretary-Treasurer,
Ontario Hospital Association

(This is the first in a series of biographical notes, introducing secretaries of provincial hospital associations.)

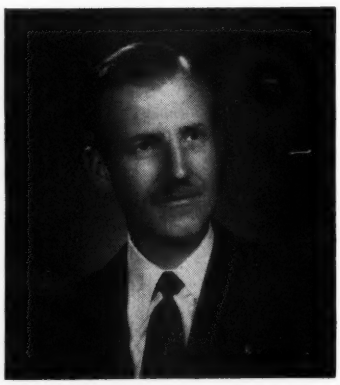
Effective July 1, 1956, Stanley W. Martin, F.C.I.S., has been appointed executive secretary-treasurer of the Ontario Hospital Association. Mr. Martin, who has been associate executive secretary-treasurer since 1951, will assume the duties of Arthur J. Swanson who resigned from office after his appointment as chairman of the Ontario Hospital Services Commission (see page 55 of this issue, and page 33 of the June issue). The announcement of Mr. Martin's appointment was made recently by Mrs. Charles McLean, president of the Ontario Hospital Association, following a meeting of the executive committee. The committee also paid tribute to the splendid contribution being made to the work of the Ontario Hospital Association by David W. Ogilvie, director of its Blue Cross Plan for Hospital Care, under whose capable executive guidance it has grown to the extent of its present enrolment of over 2,150,000 participants.

Mr. Martin is widely experienced in the field of public service, having come to the Ontario Hospital Association in September, 1951, after ten years with the Toronto East General Hospital, seven of these as assistant superintendent. Prior to that, for a number of years he had been associated with the city of Toronto's Department of Public Welfare. "Stan", as he is known to all his friends, was born and educated in Toronto, is a fellow of the Chartered Institute of Secretaries, and a member of the American College of Hospital Administrators.

During the past fall and winter, Mr. Martin served as a member of the study committee on hospital insurance appointed by Premier Frost of Ontario. He was also a technical advisor to the Ontario delegation at the recent Dominion-Provincial Conference and the subsequent conference of dominion and provincial treasurers and ministers of health, held in Ottawa in January, 1956.

Prior to assuming full-time duties with the O.H.A., he played an energetic part in the formation of their accounting section and is a past chairman of that division. In 1950 he was an active participant in four accounting institutes held throughout the province and, following the introduction of the *Canadian Hospital Accounting Manual*, he assisted in the organization of two further accounting institutes held in Ottawa and Toronto.

Among his many duties at the Ontario Hospital Association, Mr. Martin



Stanley W. Martin,
Toronto, Ont.

is a regular contributor to *Hospital Highlights* and participated in preparing the booklets *Two Sides to Every Story* and *Hospital Careers*. He has assisted in the formation of regional hospital councils in Ontario and is a frequent speaker at their meetings. He has participated in several hospital disaster institutes and is a firm believer in every hospital having a disaster plan. On several occasions he has served as a member of the faculty of the summer session of the Canadian Hospital Association's extension course in hospital organization and management.

Notwithstanding the many calls that are made on his time, he enjoys the occasional game of golf and likes nothing better than the opportunity of fishing at some secluded spot. He is a member of the Riverdale Kiwanis Club. Through his many contacts he has made a host of friends in Ontario, throughout Canada, and in the United States. — *W.D.P.*

• • • •

R. H. Stocker goes to Fredericton

Rupert H. Stocker, administrator at the Western Memorial Hospital, Corner Brook, Nfld., since 1952, will be leaving during the late summer for Fredericton, N.B., to take up similar duties at the Victoria Public Hospital. He has said that he will be leaving Corner Brook with regret. During his stay in Corner Brook, Mr. Stocker found time to serve in executive capacity with the V.O.N. organization there, the St. John Ambulance, and is currently president of the Maritime Hospital Association — which is composed of 98 member hospitals.

• • • •

Administrative Appointment at New Mount Sinai

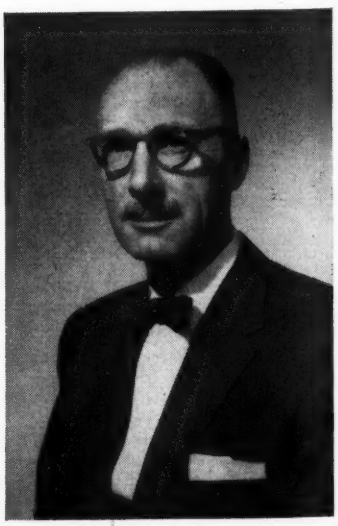
George J. Riesz has been appointed administrative assistant and administrator of the O.P.D. at the New Mount Sinai Hospital, Toronto, Ont., upon the completion of his administrative residency there. Mr. Riesz is a graduate of the course in hospital administration at the University of Toronto.

• • • •

Calgary General Appointment

The appointment of Dr. Crosby Johnston, presently assistant medical superintendent at the University Hospital, Edmonton, Alberta, as the new Calgary General Hospital administrator, was announced recently. Dr. Johnston replaces Dr. L. O. Bradley who will take up his new appointment as administrator at the Winnipeg General Hospital in August. Dr. Johnston was

(Continued on page 16)



Dr. Crosby Johnston
Calgary, Alta.

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56-51

Notes About People

(Continued from page 12)

graduated in science from the University of Saskatchewan, and in 1939 received his medical degree from the University of Alberta. He saw five and a half years service with the R.C.A.F. and received his diploma in hospital administration in 1950 from the University of Toronto.

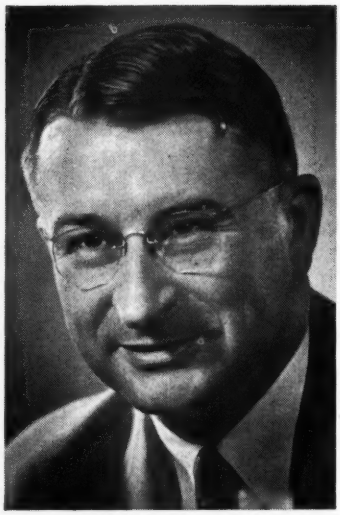
• • • •

M. B. Wallace Now Administrator of Toronto Western

Max B. Wallace, formerly treasurer and administrative assistant — for over twenty years associated with the institution — has been appointed general superintendent of the Toronto Western Hospital.

Born in Simcoe County near Barrie, Ontario, on September 19, 1901, he received his schooling at Bradford, Ontario. Mr. Wallace was engaged in commercial and industrial accounting prior to joining the staff, on January 1, 1936, of the hospital which he now heads.

Mr. Wallace is a member of the American College of Hospital Administrators, has served as chairman of the Accounting Section of the Ontario Hospital Association, and as secretary-treasurer and chairman of the Toronto Hospital Council.



M. B. Wallace,
Toronto, Ont.

Besides his hobby of colour photography, Mr. Wallace is a member of the Danforth Literary and Debating Club in which he has won recognition as a writer of short stories, and in which he has established rather a unique record in having attended for over 20 years without missing a single meeting.

Mr. Wallace succeeds Arthur J. Swanson who has resigned, after some 32 years at the helm of the Toronto Western Hospital, to accept the chairmanship of the newly formed Ontario Hospital Services Commission (see April page 12, and June page 33.)

• • • •

Director of School of Hygiene, University of Toronto

Dr. A. J. Rhodes will become director of the School of Hygiene, University of Toronto, Ont. Since the retirement of Dr. R. D. Defries in June 1955 from that position, the school has been administered by a committee headed by Dr. R. F. Farquharson. Dr. Rhodes will also head a new department, that of micro-biology, which will be an extension of the old sub-department of virus diseases. Dr. M. H. Brown has been appointed associate director of the School of Hygiene, and head of the department of public health.

• • • •

Q.H.S.

Dr. A. W. Farmer, Toronto, has

(Continued on page 22)

Notes About People

(Continued from page 16)

been honoured with the designation Q.H.S. — Honorary Surgeon to the Queen, for a two-year period. Dr. Farmer is assistant professor in the University of Toronto's department of surgery, and is a group captain, and chief consultant in surgery to the R.C.A.F.

* * * *

Newfoundland to Nova Scotia

The Roseway Hospital, Shelburne, N.S., is soon to have a new surgeon attached to its staff. He is Dr. Ronald W. Campbell, coming to Shelburne from Harbour Breton Cottage Hospital, Nfld., where he has been medical officer since October 1954. A graduate in medicine from Glasgow University in 1946, Dr. Campbell replaces Dr. D. VanHorne.

* * * *

New C.M.A. President

Dr. Renaud Lemieux, well-known Quebec City doctor, was installed as president of the Canadian Medical Association at its 89th annual meeting in June. He succeeds Dr. T. C. Routley, C.B.E., who was elected to that office as well as to the presidency of the British Medical Association in Toronto last year. Dr. Lemieux obtained his M.D. from Laval University in 1926, and in 1930 became a member of the medical staff of St. Sacrement Hospital. In 1946 he became medical director of that hospital; 1955 he was appointed to the Senate of Laval University; and one year later was named head of the department of medicine.

* * * *

Head of the Ontario Hospital Retires

The retirement, on superannuation, has been announced of Dr. Donald R. Fletcher, Superintendent of Ontario Hospital, Whitby, Ont., after 36 years with the Ontario Mental Health Service. He studied medicine at Queen's University and served in World War I until he was invalided home in 1919. During his time with the Ontario Mental Health Service, which he joined in 1920, Dr. Fletcher served as assistant superintendent at Toronto, as inspector of Mental Hospitals, and as superintendent at Brockville, prior to taking up his appointment at Whitby. Dr. Fletcher will be succeeded by Dr. D. O. Lynch, presently superintendent of the Ontario Hospital, Toronto, Ont.

• Muriel Burke, RN, and Inez (Joe) Josephson, RN, have been appointed matron and assistant matron respectively of the Williams Lake Memorial Hospital, B.C. They replace Mrs. S. Leonard, RN, who has been matron for the past two years, and Miss D. Swanson.

• Mrs. Dorothy Graham has been named superintendent of the New Waterford General Hospital, New Waterford, N.S., in place of June MacGillivray who resigned the post to enter the R.C.A.F.

• The appointment was announced recently of Mrs. Dorothy Miller of Toronto as superintendent of nursing at the Colchester County Hospital, Truro, N.S. She succeeds Mrs. Eileen Shaw, RN.

• James T. Walker, officer manager of the McKellar General Hospital, Fort William, Ont., has accepted the position of administrator of the Atikokan General Hospital, Atikokan, Ont.

• Miss Anna McLoone of Greenock, Scotland, has been appointed nurse-in-charge of Matthew Memorial Red Cross Hospital, Richard's Landing, Ont. She replaces Louise Grover, who will conduct a public health clinic for the Red Cross at Wilberforce, Ont.

(Concluded on page 68)

W. Douglas Piercey, M.D., Editor

The Canadian Hospital

Obiter Dicta

Nurse Recruitment is Everybody's Business

UNTIL recently, recruiting nurses was left almost entirely to the director of the nursing school, and very few others inside or outside the hospital gave it much thought. Today, things are different and the matter of obtaining sufficient candidates for our nursing schools should be the concern of trustees, administrators, doctors, and everyone connected with the hospital, and also the concern of the community at large.

We must recognize, however, that there are only so many potential candidates leaving high school each year, and we in the hospital field are already getting a good share compared with other vocations which are also badly in need of people. It is well known that many high school students leave at the Grade X level—what can be done to induce more to continue to Grades XI, XII and XIII? For the next few years, perhaps, this is the crux of the matter to which efforts of government could conceivably be directed.

It has been said over and over again that nursing schools are the only source of graduate nurses. If hospitals trained nurses for their own exclusive use, one could argue that this was primarily a hospital matter. However, these schools do prepare nurses for the many fields where they are urgently required; for the many hospitals without schools, the Department of Veterans' Affairs, specialized hospitals, public health, industry, doctors' offices, T.C.A., and many others. Hence it is fully time that nurse training became everyone's business and not just the business of the relatively few schools—hospital or university—which train them.

There are many facets to the over-all problem: recruitment, financial cost to the school, length of the curriculum, and the cost to the student. It may be asked whether one basic curriculum is the answer for all the areas where nurses are required. For example, does the graduate nurse employed in the doctor's office need the same course as is required by the bedside nurse looking after the seriously ill post-operative patient in hospital? These and many other questions call for an early solution and a satisfactory answer can be found only by intensive study by all groups concerned. A start can be made with the three groups which are most intimately concerned, nursing, medical and hospital. The liaison committee on nursing, representative of all three groups at the national level, can be of assistance in pointing the way. When some concrete agreement is reached on how the over-all problem can be met, then governmental assistance in one form or another is indicated.

Keeping Abreast of the Position.

A FEW years ago, when most people left school, they believed they had finished studying for their lifetime. How different things are now! The importance placed on adult education today can be readily seen from the large number of summer sessions held by our universities, the diversity of night classes conducted in high schools, and the many people taking correspondence courses.

Today hospital administrators, like any other group, need to keep abreast of their job. The question arises as to how this can be best accomplished. Regardless of our particular academic background and years of experience, it is necessary to realize first that these in themselves are not sufficient in assisting us to give maximum performance in our position. We have to seek constantly to widen our knowledge, to keep abreast of trends, and to know what our associates are doing.

In the field of hospital administration, many opportunities are afforded today for study which were not available formerly. For those wishing to enter the field there are the university courses in hospital administration. These offer an excellent opportunity for the student to learn the basic concepts of the complex relationships involved in the operation of a hospital. For those already in the field there are regional meetings, association con-

ventions, institutes of various types, and the extension course in hospital organization and management. These all help to augment the experience we gain from our daily work.

Students in university courses in hospital administration and those taking the extension course are well aware that a most important part of their education is the reading of recognized textbooks and current hospital journals. These are the foundation upon which all else stands. Some of our most successful hospital administrators are people who never had the opportunity of taking formal courses in hospital administration; yet they found time to read, to attend meetings and institutes, and thus have literally educated themselves. Similar examples from other walks of life are easy to find.

If we are among those who have not had the opportunity of formal courses in our own field through no particular fault of our own, we should not bemoan our fate and let it go at that. Neither should we say to ourselves that our situation is different or that our duties are so onerous that we have little or no time to read. Neither should we delude ourselves into thinking that our own experience is sufficient—because experience can be a bad teacher. If we have been using a wrong method for a number of years, we will continue to do so until we learn that there is a more efficient method.

What is required most is to be aware of our own shortcomings and to have the desire to improve our techniques of management and to acquire new ideas. Once we have the will, we will find time to read all we can about our subject. Reading will give us new facts, but—much more important—it will bring new ideas to broaden our horizons, and that is the important feature. A wide knowledge of hospital literature is more important today than ever before. Do you have the will to keep abreast of your vocation?

Une Occasion Excellente

BEAUCOUP de gens du monde hospitalier ont eu l'occasion, pendant les mois de mai et de juin, d'échanger leurs vues, et de se renseigner, à quatre assemblées importantes: l'Association des Hôpitaux Maritimes, à St-André-sur-Mer au Nouveau-Brunswick, l'Institut du Canada de l'ouest pour administrateurs et gouverneurs d'hôpitaux, à Vancouver en Colombie Britannique, le Comité des Hôpitaux du Québec, et le cours d'été du Collège Huron à London, Ontario.

Cette année, 140 étudiants ont assisté à la session d'été qui fait partie du cours d'extension pour l'étude de l'organisation et de l'administration d'un hôpital, dirigé par l'Association des Hôpitaux du Canada. Ils venaient de toutes les provinces du Canada pour approfondir, pendant leurs quatre semaines en résidence, leur connaissance des matières étudiées pendant la session d'hiver, pour écouter les conférences données par des autorités dans des domaines importants de l'administration d'un hôpital, pour discuter en groupes de problèmes spécifiques et participer à d'autres groupes de discussions. L'occasion de se connaître et d'échanger des idées durant leur période en résidence, constitue un des aspects importants de cette session.

Personne ne peut calculer toute l'influence de ces quatre assemblées sur le programme d'amélioration administrative des hôpitaux du Canada. Il sera considérable, nous en sommes certains. Ceux qui y ont assisté auront élargi leur visions, recueilli des faits plus récents et auront été stimulé par des idées nouvelles. En retournant à leurs hôpitaux respectifs, ils y porteront l'influence de ces réunions, au grand profit de leurs institutions. C'est pourquoi nous jugeons ces assemblées d'une si grande importance.

A Grand Opportunity

DURING the months of May and June, many hospital people throughout Canada have had an opportunity to compare notes with each other at four important meetings. The Maritime Hospital Association convention at the Algonquin Hotel, St. Andrews-by-theSea, held May 29th-31st, afforded an opportunity to some 350 delegates from the four Atlantic provinces to exchange views and to be brought up to date on many important hospital topics. The Western Canada Institute for Hospital Administrators and Trustees, held on the campus of the University of British Columbia, June 11th-15th, was well attended by delegates from the four western provinces. The annual meeting of the Comité des Hôpitaux du Québec, June 25th-27th, as in former years, provided a comprehensive program both inspirational and educational. In addition, another large group attended the summer session at Huron College, University of Western Ontario.

The summer session, an integral part of the extension course in hospital organization and management, sponsored by the Canadian Hospital Association, was attended this year by 140 students from June 4th to 26th. The students were from all provinces of Canada, and during their four weeks in residence an excellent opportunity was afforded to round out the lesson material of the winter session, to hear lectures delivered by hospital authorities on important phases of hospital management, to participate in problem clinics, and to take part in seminars. Undoubtedly, the opportunity to learn from each other during their close association in residence was as important a feature of the session as any.

No one can estimate the full impact of these four meetings on improved hospital administration throughout Canada. That it will be considerable we can be certain. Those who attended will have broadened their horizons, learned new facts, and will have been stimulated by new ideas. As they return to their respective hospitals, they will take with them what they have gained at these meetings for the benefit of their institutions. Therein lies the importance of these splendid opportunities.

Can You Laugh at Yourself?

SOME departmental heads and hospital administrators are so obsessed with the importance of their own position and are so busy with their daily routine, that they never take time out to have a good look at themselves. If we all did this occasionally and were able to laugh a bit at what we saw, it would help immeasurably. Certainly it would do much to relieve the emotional tension under which we work and would make life more pleasant for those who work closely with us.

A successful hospital administrator, who never appears to get ruffled, who seems to work at a very even tempo and never appears angry, confided to me that he has learned to have a good laugh at himself every now and then. When he assesses himself he realizes that he has three personalities: there is the person he thinks he is, the person his associates think him to be, and the person he really is. While constant introspection is psychologically bad, it is a sign of maturity when we occasionally take a quiet, good look at ourselves and can laugh a bit at our own expense. By the way—have you had a good laugh lately?

The continuing battle against

Staphylococcus Aureus

Saskatchewan 1955

H. O. Dillenberg, M.D.,
Bacteriologist,
Department of Public Health,
Regina, Sask.

REPORTS on cross infections with M. pyogenes and of epidemics with strains of staphylococcus aureus resistant to treatment have come from many parts of the world and other provinces of Canada in past years. In Saskatchewan, also, this "yellow pest" has created concern. A number of hospitals have had cross infections that have put a heavy strain on the medical and nursing staffs, have led to secondary infections of patients with surgery or internal diseases, of newly born infants in nurseries and their mothers, and have in general been very costly. One of the largest hospitals in the province has suffered since August 1954 from an epidemic with this organism and, though the situation has been brought under some control, the cross infection still is going on and cannot possibly be eradicated so long as this hospital serves a large part of the Saskatchewan public under a number of handicaps. In general an increase of staphylococcal conditions is noted throughout the province.

From January to September 1955, the provincial laboratories isolated 608 strains of M. pyogenes, var. aureus, from 2,658 specimens submitted for diagnostic bacteriology from hospitals and physicians of the countryside. In the same period in 1954, 346 isolations were made from 2,294 specimens. This means an increase from 15.5 per cent to 22.8 per cent. The positive specimens of this year came from 79 different communities, as compared with 51 in 1954.

Ten communities of the 79, in 1955, show a steady monthly rise in the isolations of M. pyogenes and, from the analysis of drug resistance of the strains involved, it can be concluded that chain infections with one or two identical strains are going on in these places.

The resistance of the isolated strains towards antibiotics has markedly increased. Besides the high rate of failures of penicillin, noted already after its introduction into general medicine ten years ago, the broad spectrum antibiotics also show an increasing rate of failures against this organism.

A comparison of the eight antibiotics most commonly administered against strains of M. pyogenes (isolated in the Provincial Laboratories in 1954 and in 1955) shows the following data:

Failures	1954	1955
Penicillin	70.4%	68.2%
Streptomycin	62.2	68.2
Aureomycin	26	34.5
Terramycin	43	52.2
Achromycin	28	33.8
Erythromycin	2	21.8
Bacitracin	22	25.5
Chloromycetin	1.6	8.1

In the series of 553 strains tested against antibiotics in 1955, none were found to be resistant towards *all* antibiotics. Usually erythromycin, bacitracin, or chloromycetin offered effect when the tetracyclines or penicillin failed. However, verbal communications from practising physicians state staphylococcal conditions to have been uninfluenced by any of the listed drugs. This corresponds with reports from large centres in the U.S.A. where a frantic search for effective antibiotics has been staged for many months. The requests for staphylococcal autovaccines, for treatment of these refractory cases, have steadily increased in our laboratories and mean a heavy burden for our staff.

Phage typing of more than 1,300 strains of M. pyogenes, var. aureus, isolated either in our laboratories or submitted from other bacteriological sections, revealed indeed that a number of *epidemic* strains are being spread and that one strain, especially No. 81, is a main culprit when chain infections, cross infections, or serious staphylococcal conditions are encountered. This strain also feeds, together with five other epidemic strains of lesser virulence, the continuous epidemic in the large hospital mentioned above. It could be ascertained as the causing agent in at least eight fatal outcomes where the bacteriological investigations were conducted in our laboratories. Two of these fatal cases have contracted their secondary staphylococcal infection *in* the hospitals. With the other this cannot be stated as certain.

Phage type 81 has been isolated finally from a number of milk samples that were submitted, for a survey on cattle mastitis, to Dr. Abelseth, the veterinarian in the provincial laboratories; and it has also been isolated from the stools of a farmer who contracted a staphylococcal food poisoning after consumption of stale hotdogs at the provincial exhibition last August. Four other members of his family were reported to have been sick from the same reason but were not in hospital.

These data are taken only from the results in the provincial laboratories. The isolations of M. pyogenes in the large hospitals of the province were similarly frequent and alike in pattern.

What Is It?

What is this staphylococcus and how does it spread?

It is a tiny, ball-shaped micro-organism, which multiplies by fission into two daughter cocci every 12 to 20 minutes and forms clusters which in turn form visible colonies with a golden-brown pigment after about 6 to 8 hours on our media. It feeds on organic matter of any origin which it assimilates by means of enzymes and it may cause the breakdown of living tissues by means of proteolysins, lipolysins, haemolysins, and other toxic enzymes. It prepares its spread into wide areas of the invaded tissues by the production of hyaluronidase which liq-

From an address presented at the annual convention, Saskatchewan Hospital Association, October 1955.

uefies fibrin and collagen readily. It also produces toxins with more than local effects that seem to paralyze vital organs and perhaps also nervous centres in terminal stages of systemic infections. All animals and man are susceptible.

More often than as infectious agents, however, staphylococci will be found as saprophytes among the normal flora of nose, mouth, respiratory tract, and the skin. In this saprophytic stage they feed on the debris of the skin or the excreta of the mucous glands. They may even live harmlessly for a period in the blood or the lymph. About 4 to 10 per cent of our general public harbour staphylococci continuously as healthy carriers, and all of us will carry them unknowingly at one time or another. They have been with man, probably, since the beginning of human history. Even the notorious epidemic strains like this 81-strain may live as commensal in our nose and skin and cause no harm. We have not yet found an increase of virulent strains among our healthy population.

We may find them in a resting stage everywhere else. If they starve or are submitted to temperatures below 15 degrees C., they cease multiplying but may remain viable for indefinite periods. As soon as the temperature rises and enough food is offered they will reproduce again and thus may contaminate improperly stored food and produce food poisoning enterotoxins in custards, milk, et cetera, that have been left over from meals and outside the icebox for some time. They are one major concern of the sanitary inspectors.

Frequently these saprophytes become fierce parasites. Whenever they find a port of entry into a weakened tissue or whenever they infect a patient with general ill health, they tend to display pathogenic properties. Many diseases of humans are due to this: boils, impetigo, pyogenic inflammations of any site of the human body, especially breast abscesses, sore throat, broncho-pneumonia, abscesses in any organ, septicaemia and the fearful staphylococcal septicopyaemia, et cetera, to name only a few. The body may keep them under control, as fortunately happens in most cases, or they may overwhelm the patient within short hours as they did in millions of instances during the influenza pandemics. Many parasitic staphylococci have increased in virulence; they may cause further disease in any new victim of weakened resistance.

They spread usually through contact from person to person, through contamination of commonly used utensils, less often through droplet infection or aerial conditions. However, should a nurse handle the skin, dressings, clothes, bedsheets of a patient with staphylococci, she is bound to contaminate herself, unless she applies strictest protective techniques. She will inevitably then contaminate her nasal pathways and from there, as the staphylococci thrive in the nose, again and again her hands. It is plain how easily she will carry it to other patients. In fact, all medical institutions will have a high carrier rate among their personnel. This is impressively demonstrated by taking the carrier rate among student nurses before starting their course and a few days afterwards. English investigators have demonstrated an increase from 5 per cent to 90 per cent within eight days in a maternity hospital.

To give an example: A farmer with a neglected neck carbuncle has to be submitted for surgery. His dressings, his shirt, his bed sheets and blankets, anything he touches, will be contaminated. The dressings contaminate either his physician or the nurses; his laundry contaminates the ward-aid, the elevator-boy, the laundry personnel; his blanket may contaminate the charwoman. He shakes hands with others on the ward who will be contaminated. He shakes hands with his visitors who will contaminate the doorknob. He goes to the bathroom and he will contaminate the bowl and probably the next patient who goes to stool.

The nurse and the physician may carry it to other patients; the ward-aid may handle other equipment; the laundress contaminates her hands with the dirty sheets, will inevitably touch her nose, and from there will bring staphylococci back to clean laundry that goes to a ward.

Now, this is how it may spread. It does not necessarily mean disease in other individuals at all, but it may for some. And as one case with boils may already pollute his environs and the involved personnel to a large extent, two or more certainly do so to a much greater extent. A cross infection becomes manifest when patients who have been in hospital for some time suddenly develop staphylococcal conditions, and especially when newly born babies start having pimples. To neglect any staphylococcal conditions in any hospital may mean cross infection, may sometimes mean disaster.

I shall never forget the narrative of a physician of high standing who saw his babies leave the maternity ward apparently healthy, to have them back a few days afterwards in his office with boils or impetigo. But one mother came and said: "Doctor, what is wrong with my baby? It has not got a boil since we left the hospital." This happened two years ago in a 40-bed hospital in this province and the strain involved was No. 81.

To continue with this example: We were called to assist in this apparent cross infection and started as we should with any cross infection. We checked everything bacteriologically, by taking swabs. We found 70 per cent of the hospital staff contaminated, found staphylococci in the ointment-jar in the nursery, found them in the string pearls for the babies, on the doorknob of the nursery, on the spectacles of the nursery sister, in the sponges of several packs, after they had been autoclaved, in the face powder of a nurse's aid, on her diamond ring, on the baby bottles which she handles, on the soles of the oxfords of the O.T. nurse, in the bedsheets fresh back from the laundry, on the knob of the elevator and, to end this incomplete list, in high numbers on plates which we exposed to the air of the nursery room.

But we also found hostility on the side of some nurses and aids — which was the real reason for the mess. One elderly sister told me she did not believe in our findings. In the 30 years she had nursed, there were always boils and pimples and it did not matter. Nobody started a fuss. She was right —cross infections and staphylococcal conditions have always happened in hospitals and, often, have been regarded as a minor nuisance in mixed or general hospitals; but we had certain differences in the administration of hospitals and the employment situation in those days. I may say something aggressive here, but it seems that you could then ask your staff to do more work than you can today, to do more cleaning and to do it twice in one shift, if necessary. Today we do not often find the sergeant-type of head nurse that it takes to cope with emergencies like a cross infection. Another difference may be that, in those days, the bugs were not as vicious as they are now-a-days. I am asked to bring scientific facts, so I had better leave the question of the 5-day week and short-hour work to those who think we should in the end have a 5-day week with 6 hours a day, or better a 4-day week — and deal only with this increased viciousness of our epidemic staphylococci.

Penicillin

When penicillin proved its value in the treatment of wound infection during the war, hope was high that staphylococcal conditions would never be a danger again. This was soon found to be wrong. From natural contact with penicillin-producing moulds, strains of staphylococci already were existent

(Concluded on page 74)

A Challenge to Hospital Administrators

Time and Motion Study

C. F. Ellis,
Assistant Administrator,
Royal Edward Laurentian Hospital,
Ste. Agathe Des Monts, P.Q.

IN JUNE, 1955, a question was posed to a group of hospital personnel representing hospitals from parts of Canada and the United States, one from France, and one from Venezuela. The group comprised a number of students in the 1955 graduating class of the Extension Course in Hospital Organization and Management; a course sponsored by the Canadian Hospital Association and financed to a large extent by the W. K. Kellogg Foundation. The students were not students in the usual sense of the word. They were people in administrative positions in hospitals — administrators, assistant administrators, medical directors, personnel officers, superintendents of nursing, purchasing agents, and others. They were gathered together, not only to study the theory of hospital organization and management, but, also, to exchange ideas born of years of practical experience in the field of hospital administration.

The question asked was: "How many of the people present have conducted, or have had conducted in their hospitals, a time and motion study in any department?" Response to the query was totally negative. In other words, not one hospital represented had a true knowledge of whether their costs were justified. Now this is a challenging statement and a challenging interpretation of the response to the question. However, the intent of this article is to challenge — to challenge hospital administrators in every hospital to look closely at the meaning of the word "justification" and to answer the questions "Are our costs justified?" and "Is our patient care the best we can give?"

We see many hospitals today wherein costs are broken down to the fraction of a cent. By so doing management feels that it has justified increased charges to the public and increased demands on the government agencies.

There is no quarrel with knowing costs. One must always know them and have them as finely broken down as is practical. But one must also know whether the costs themselves are justified. One cannot justify a hospital's per diem cost by telling all and sundry what the cost is. Nor can one justify it by breaking down the cost into cost of an operation, cost of an x-ray picture, cost of drugs, cost of power, cost of meat, pies, bread, or anything else. Breakdown of cost still only tells cost and perhaps some hospitals already break down costs too far and spend too much money on elaborate systems to determine costs. Others we know do not go far enough. There must be a happy medium. But regardless of what costing is done, we must still know if the cost itself is justified.

How many employees are there in hospitals who are so busy that it is utterly impossible for them to do each of their tasks thoroughly and well — or, conversely, how many employees are there in hospitals earning a full day's pay for half a day's work? These questions may promote all kinds of discussion but finally it will be realized that a time and motion study is required before they can be answered conclusively. It has been said that no man objects to a full day's work if paid for it. But what constitutes a full day's work can only be found through a time and motion study.

Meaning of a Time and Motion Study

What is a time study? The term refers to a detailed study of the actual time it takes to accomplish the various motions of any given task. It is economy of motion and not the speed with which the elements are performed that is the purpose of a time and motion study. Its purpose is to find out how much work should be produced each day by a normal employee. In the words of Frederick E. Markus of Markus and Nocka, Industrial Engineers, Boston, Mass., the aim of such a study is to supply data for work simplification, and work simplification, he says, has four objectives: (1) to save time; (2) to save space; (3) to save energy; and (4) to save material. All other purposes should, under an ideal set of conditions, become by-products of the four major or basic objectives. Other purposes may include a desire to increase salary and wage rates or to compensate for staff shortages. However these and others should hinge on the first four.

By Guess — or by Time Study?

How do we know our work schedules are correct if we have never timed them? Is the establishment of a work force to be left to chance? Is the patient or bed count the sole criterion of the size of staff? Are we going to copy our neighbours to determine staff or should the size of staff and the work schedule be deduced from a thorough study of the time and motions involved?

Cost to the parties responsible for paying the bill is, or should be, one of our prime responsibilities. Our objective should be to provide the patient with the best possible care for the least possible cost. To say so is only to repeat what has been said so many times before by many better qualified to say it. However, how do we know if we are supplying the best possible cost, if we do not know whether five or seven people should be employed to do a job? If we do not know whether we are supposed to supply 1,000 or 1,100 cubic feet of space at a dollar and a half per cubic foot? If we do not know whether 700 or 725 pounds of material are required?

Is it possible to make up for staff shortages or what we believe today to be staff shortages? Is is possible to increase pay standards of hospital employees and still retain a sympathetic public? The only answer to all these questions is a time and motion study. And only a time and motion study can take the guesswork out of the problem of justifying costs.

Pick a Number, Any Number

We should have said, pick a department, any department, and carry out a time study, and the odds are that you will be surprised.

The first department to act as a guinea pig in our hospital was the laundry. Our initial step was to weigh linen. It is not necessary to weigh linen every day in the year but it is necessary to do so for several weeks to establish an average and to arrive at the work load. Thereafter it may

(Concluded on page 76)

Lethbridge Municipal Hospital

Symbol of Prosperous Southern Alberta

THE Lethbridge Municipal Hospital opened its doors to the first patient on June 1, 1955, the culmination of many years of hard work by a group of public-spirited citizens who realized that Lethbridge needed a new hospital. That they had to work so hard is attested by the fact that three plebiscites were necessary before the first sod was turned. The need for a hospital is shown by the number of babies who have been born here already, the number of operations performed and the great number of people who have been cared for both as in- and out-patients.

This hospital, situated in the city of Lethbridge, is operated by The Lethbridge Municipal Hospital District No. 65 which comprises an area of over 2½ million acres with a population of some 50,000 people. However, although the hospital district built the hospital primarily for residents of this immediate area, the specialized facilities are available and used by a trading area population of well over 100,000. Lethbridge is the medical centre as well as the trading centre for southern Alberta. That this is a progressive area is recognized by the advanced design and top quality equipment and facilities provided in this new modern hospital.

The firm of Townley and Matheson of Vancouver, B.C., was commissioned in 1948 as architects for this project, which includes a 130-bed nurses' home just recently completed adjacent to the hospital and connected to it by a tunnel. This firm, specialists in this type of architecture in western Canada, spent many months in planning and designing before submitting preliminary sketch plans. After many more

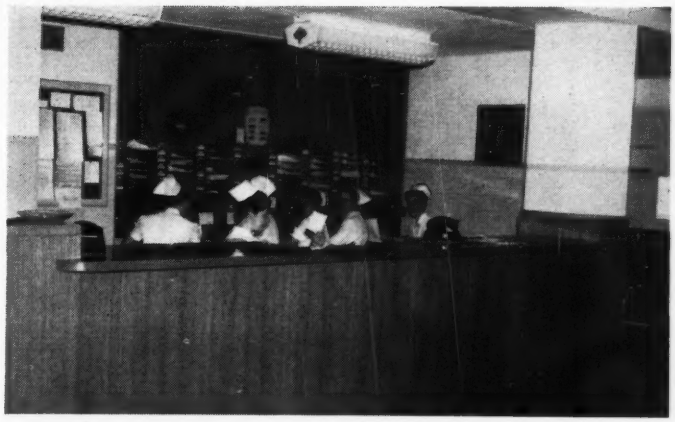
In addition to public waiting rooms on each floor, on the maternity floor there is a fathers' waiting room which has an authentic western motif.

John MacKay, D.H.A.,
Administrator,
Lethbridge Municipal Hospital,
Lethbridge, Alberta.

months of research and consultation with experts in allied engineering fields, with nursing and medical staffs, and finally with the administrator and board, the plans were approved.

The floor plans here show very clearly the design of the building which provides for an additional wing to house approximately 85 patients without adding any further service facilities. All such facilities as presently shown were planned to take care of additional beds. The construction costs were a little higher than might normally have been expected since all plumbing, heating, and electrical services have been carried to the point of contact for the future wing and, at the present rate of population increase in sunny south Alberta, it will be relatively few years before this wing becomes a reality.

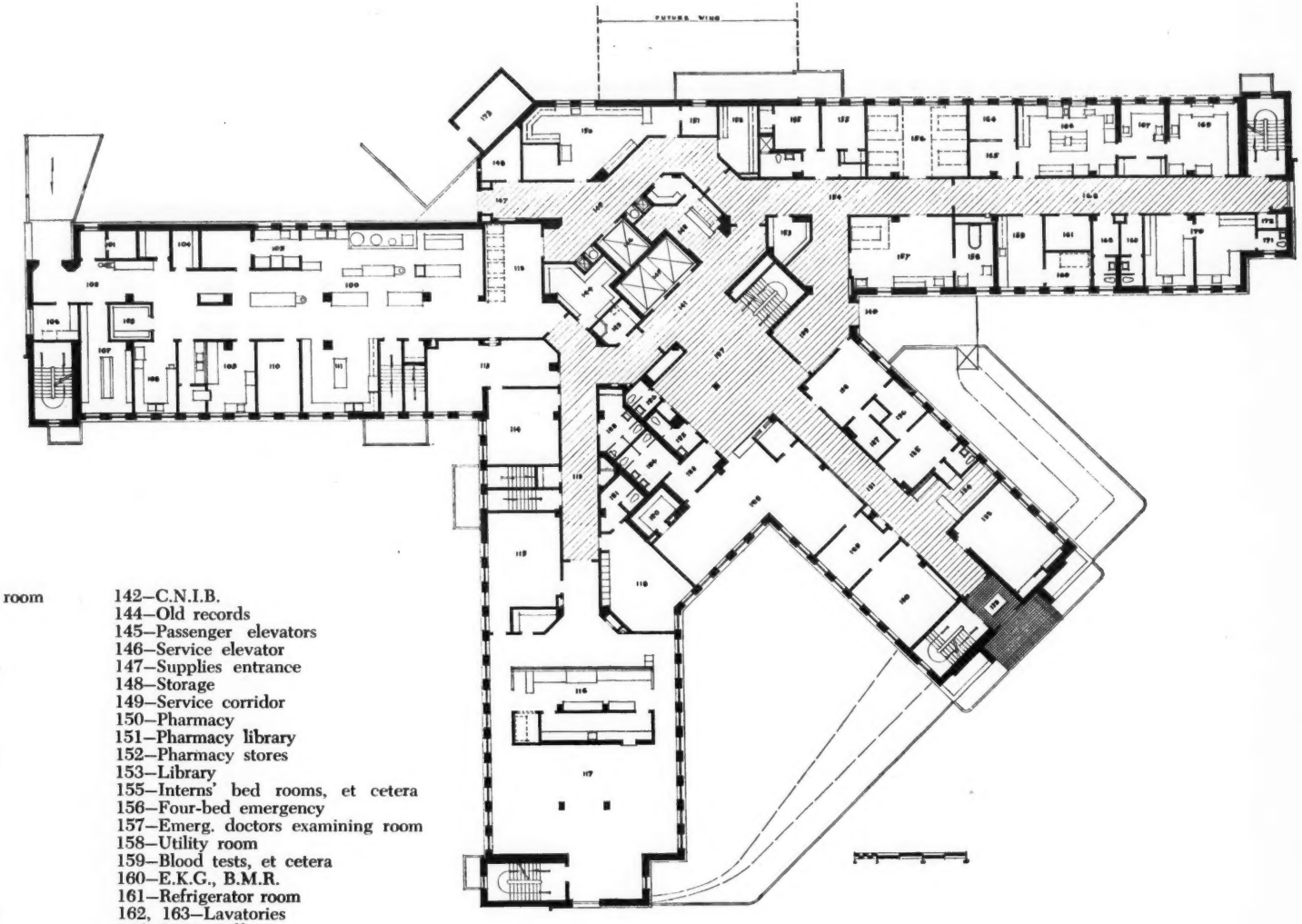
The general structure of the building is poured reinforced concrete walls, floors and columns. The room partitions are all plaster on hollow tile; ceilings are suspension type and in most areas are random-punch acoustic tile. With the exception of service areas and wash rooms the floors are all oxychloride terrazzo with base of the same material. The service area walls and floors are finished in ceramic tile. The windows in the building are of a removable metal-sash type with a combination storm sash and screen for year-round use. They give an air of brightness and cheer both to the patients' rooms and the service areas in the building. They may be removed in a very few seconds, replaced by a clean unit, and then taken to a central area for washing prior to being placed in the next window. The exterior of the building is a combina-



One of several nurses' stations. Charting desk is seen in background.

The general office shown here and other administrative offices are grouped around the main waiting area.

A 4-bed ward, the largest unit in the hospital. Special features are a radio loudspeaker on the pillow, and an over-bed light, focused for reading.



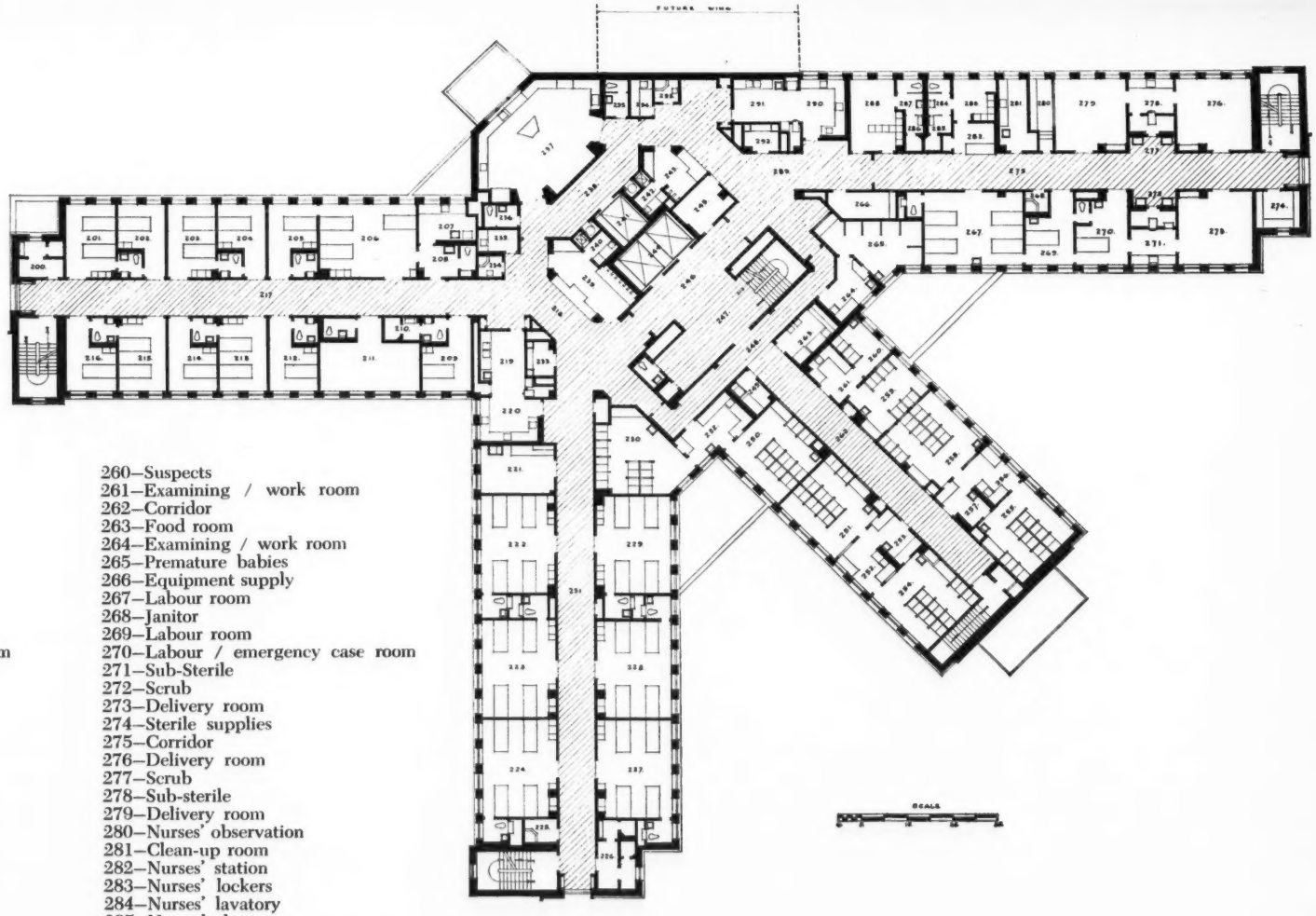
100—Main kitchen
101—Garbage
102—Veg. prep.
103—Deep freeze
104—Walk-in refrig's
105—Meat cutting
106—Vegetable stores
107—Dry stores
108—Salad preparation
109—Bottle wash / formula room
110—Dietitian
111—Special diets
112—Food truck parking
113—Medical records, active
114—Doctors' lounge
115—Small dining room
116—Cafeteria service
117—Main dining room
118—Staff / nurses' lounge
120—Vault
121, 122—Lavoratories
123—Staff coat room
124-126—Lavoratories
127—Stair hall
128—General office
129—Secretary
130—Administrator
131—Administration corridor
132—Main entrance
133—Board conference room
134—Enquiry / Switchboard
135—Superintendent of nurses
136—Ass't superintendent of nurses
137—Chest x-ray
138—Admitting office
139—Emergency waiting
140—Ambulance entrance
142—C.N.I.B.
144—Old records
145—Passenger elevators
146—Service elevator
147—Supplies entrance
148—Storage
149—Service corridor
150—Pharmacy
151—Pharmacy library
152—Pharmacy stores
153—Library
155—Interns' bed rooms, et cetera
156—Four-bed emergency
157—Emerg. doctors examining room
158—Utility room
159—Blood tests, et cetera
160—E.K.G., B.M.R.
161—Refrigerator room
162, 163—Lavatories
164—Private office
165—Secretary
166—General laboratory
167—Sterilizing
169—Bacteriology / serology
170—Pathology laboratory
171—Lavatory
172—Janitor closet
173—Oxygen stores

Ground Floor: Dietetics, Pharmacy, Admitting

140—Ambulance entrance
173—Oxygen stores

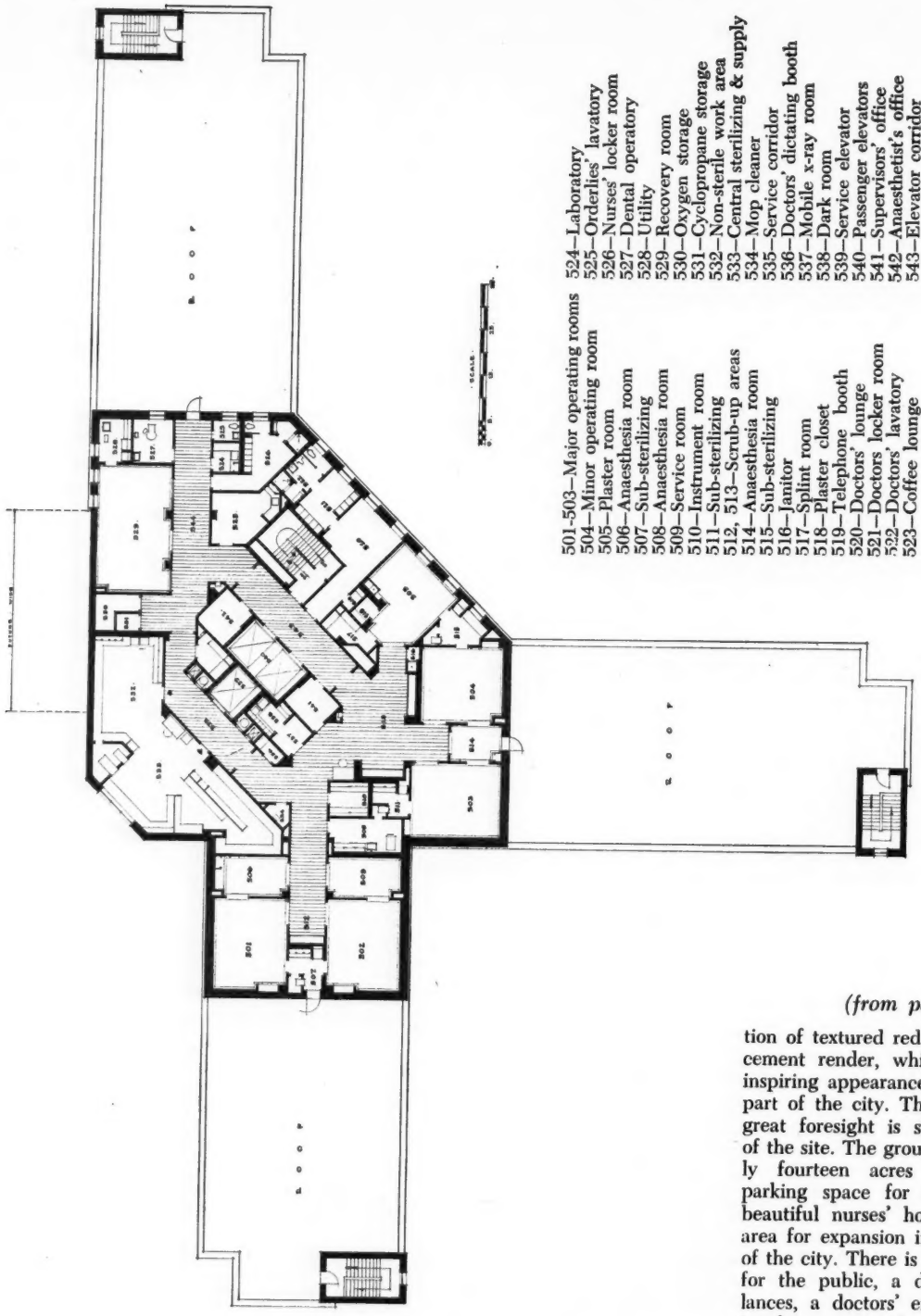
Ground Floor: Dietetics, Pharmacy, Admitting

200—Shower
201—Semi-private ward
202—Private ward
203—Semi-private ward
204, 205—Private wards
206—Observation
207—Sub-utility
208—Scrub
209—Private ward
210—Shower
211—Patients' sitting room
212—Private ward
213—Semi-private ward
214—Private ward
215—Semi-private ward
216—Private ward
219—Clean-up area
220—General utility
221—Drs. examination treatment room
222-224—Four-bed wards
225—Janitor
226—Showers
227-229—Four-bed wards
230—Nursery
232—Examination / work room
233—Linen room
234—Janitor
235—Flower room
236—Nurses' lavatory
237—Diet kitchen
238—Service corridor
239—Nurses' station
240—Medicine room
241—Service elevator
242—Medicine room
243—Nurses' station
244—Passenger elevators
245—Supervisor's office
246—Elevator corridor
247—Stair hall
248—Nursery corridor
249—Infants bath
250, 251—Nurseries
252—Work room
253—Examining room
254, 255—Nurseries
256—Work room
257—Examining room
258, 259—Nurseries



260—Suspects
261—Examining / work room
262—Corridor
263—Food room
264—Examining / work room
265—Premature babies
266—Equipment supply
267—Labour room
268—Janitor
269—Labour room
270—Labour / emergency case room
271—Sub-Sterile
272—Scrub
273—Delivery room
274—Sterile supplies
275—Corridor
276—Delivery room
277—Scrub
278—Sub-sterile
279—Delivery room
280—Nurses' observation
281—Clean-up room
282—Nurses' station
283—Nurses' lockers
284—Nurses' lavatory
285—Nurses' shower
286—Doctors' shower
287—Doctors' lavatory
288—Doctors' lockers
290—General utility
291—Clean-up area
292—Linen
293—Janitor
294—Flower room
295—Nurses' lavatory

Second Floor: Obstetrics, Nurseries, Paediatrics



Fifth Floor: Surgery

Architects:
Townley and Matheson,
Vancouver, B.C.

(from page 37)

tion of textured red brick and painted cement render, which gives an awe-inspiring appearance visible to a great part of the city. That the Board used great foresight is shown by the size of the site. The grounds comprise nearly fourteen acres providing paved parking space for over 250 cars, a beautiful nurses' home and adequate area for expansion in a central section of the city. There is one main entrance for the public, a drive-in for ambulances, a doctors' entrance and parking lot on one side and staff entrance on another. The main lobby, which is situated adjacent to the admitting office and the elevators, is furnished decoratively but also functionally.

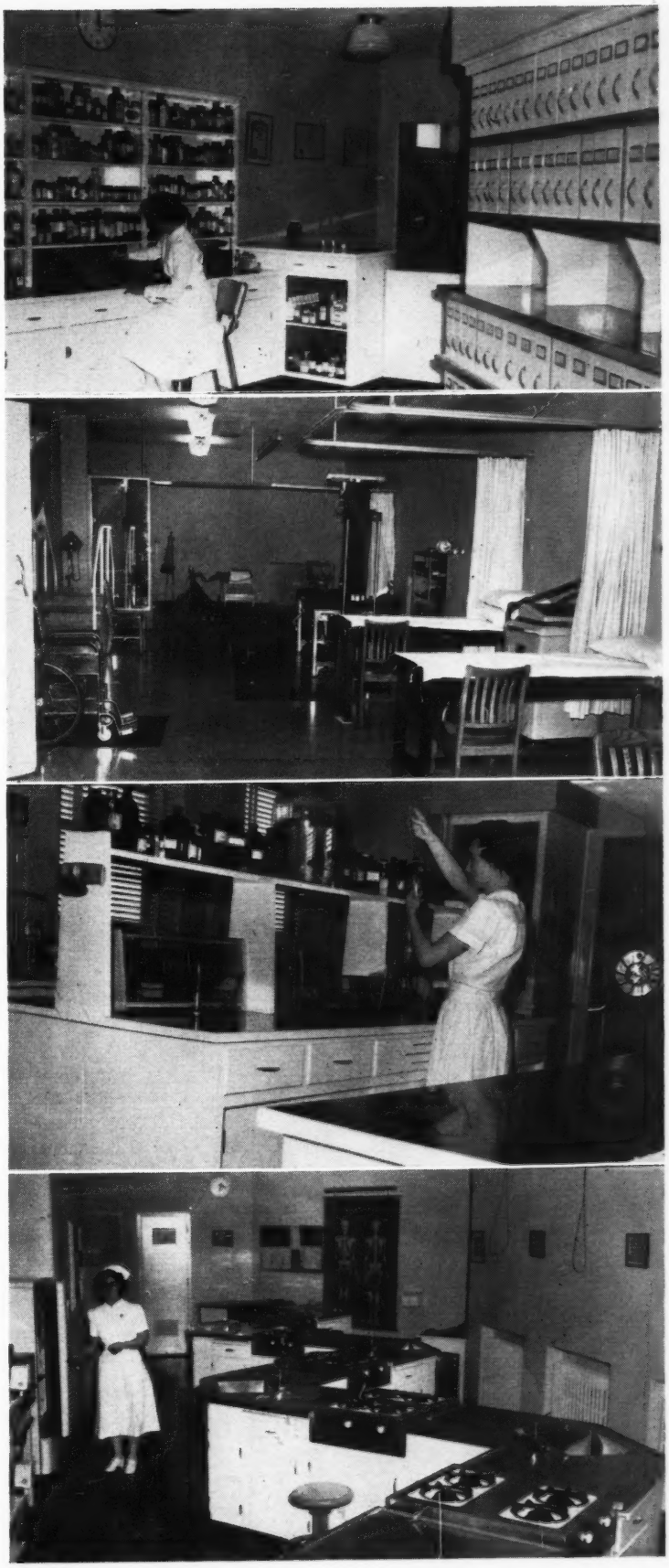
Here, as in practically all other areas of the hospital, simulated leather upholstery in various shades was used to cover the furniture, giving a bright cheery effect—while, at the same time, offering a hard-wearing, easily-cleaned material. The building encompasses

five floors above ground and one below ground level. There are fire stairs at the end of each wing with a central stairway in the middle. The stair nosings are carborundum impregnated so as to provide a non-slip surface which is proving very effective. In addition, the building houses two automatic-control passenger elevators, an automatic service elevator and two dumb-waiters. The building is so designed that when loaded the dumb-waiters open directly into the medicine rooms adjacent to the nurses' station so that they are not accessible to the public. This is a very convenient and tamper-proof arrangement.

Service Areas

The laundry and boiler plant are situated in a separate building connected to the hospital by an underground tunnel which also services the nurses' home. The plant equipment includes three package steam generators, the output of any two will provide for the maximum requirements of the hospital and nurses' home; these units are fired by natural gas, but there is an oil stand-by in case of emergency. The water-softening system with a capacity of 35,000 gallons provides an adequate supply of softened water. Pressure tanks and pumping equipment providing 85 pounds of water pressure on the fifth floor of the building are a very necessary safety measure, while the gas-operated stand-by lighting system will furnish electric power for all operating rooms, case rooms, nurseries, fire stairs, and corridors. Here again the provision of an adequate margin of safety has been provided by the architect in his equipment design.

The sub-ground floor of the hospital proper contains four separate wings. The out-patient wing has a separate entrance in addition to being close to elevator service. Here we find a large waiting area complete with magazine rack and the latest journals, adequate seating, six large examining rooms, office space and a small laboratory on the south side of the corridor. The physio therapy department is situated on the north side. It is well designed with office area and wash rooms, and fully equipped through the aid of federal health grants. The radiology department, which is located in another wing, is a complete entity with its own waiting area, reception desk, two large diagnostic rooms, a therapy room equipped with radium, deep therapy

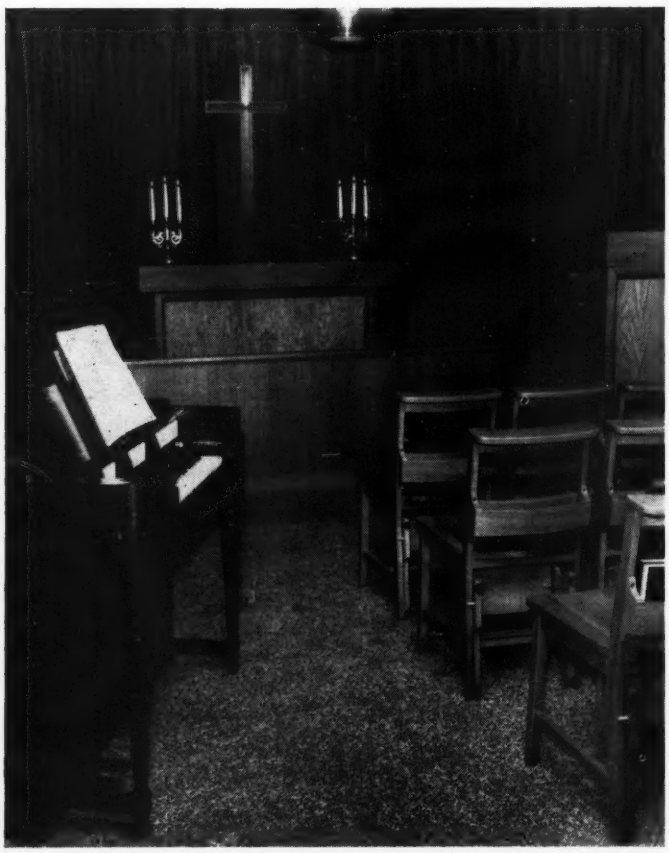


Shown here in order of appearance:
Pharmacy showing special steel drug filing cabinets on the right.
Physio-therapy department.
Chemistry laboratory.
Student nurses' diet laboratory.

Switchboard, showing doctors' "in" and "out" register which is relayed from doctors' entrance.

and superficial therapy machines, dressing cubicles, an examining room, doctors' viewing room, and a modern dark-room. The third wing on this level is devoted to students' classrooms, dietary laboratory, demonstration room, and library; the remaining sub-ground floor area contains a morgue, stores, and linen room.

The ground floor contains the general administration, admitting, emergency, laboratory, pharmacy, dietary and medical records departments. The spacious offices for general administration are grouped around the main waiting area, readily accessible to patients, visitors, and staff. Quarter-cut oak panelling in the board room and the main corridor lend a warm tone to what is generally considered the coldest part of the hospital. The admitting office is equipped with a miniature chest machine and is adjacent to the ambulance entrance. On the other side of this entrance is the emergency operating room which is complemented by a four-bed emergency ward. This has proved to be of inestimable value in the short period the hospital has been in operation.



Inter-denominational chapel on the medical floor provides sanctuary. Services for staff and patients are conducted here.

The clinical laboratory and pathology departments are near at hand, providing suitable quarters for general laboratory, as well as tissue, biochemistry, serology, and bacteriology divisions. In addition to these facilities there is a small "quick section" division on the operating room floor and a further unit in the out-patient wing, thereby enabling the patients to receive service rapidly and efficiently at all times. The dietary department occupies the greater part of two wings on this floor. There is a decentralized food service, with the food being transported to the cafeteria on the same floor, and the ward kitchens on the second, third, and fourth floors, by means of heated food trucks.

Special diets are prepared and packaged in meal packs in a subdepartment of the main kitchen, while milk formulas are also prepared here under the strict guidance of qualified dietitians. Individual walk-in refrigeration for meats, dairy, fruit and vegetable products, in addition to a walk-in deep-freeze and refrigerated garbage room complete the modern equipment in this department. Through the use of ceramic tile on the walls, stainless steel counters, tables and sinks, and quarry-tile floor, this division is a picture to behold—as well as being easily kept clean. The pharmacy is also situated on this level and is so arranged as to provide for a full range of supplies, a reading room, very extensive bin space complemented by a drug filing cabinet, in addition to a small office tastefully decorated in blue and white. The Medical Record Library and the adjoining doctors' lounge complete the ground floor—giving an added incentive to the medical staff to complete their records. In addition to the dictating facilities in this office there is a dictating unit situated in each nurses' station which records by remote control at the record office in order to promote hastier completion of charts. Experience has shown that this investment was a wise one.

The second or maternity floor provides accommodation for forty-two mothers and babies. One wing is devoted to nurseries where there is a maximum of eight bassinets to the individual nursery and each baby has a glass-partitioned cubicle. There is a small suspect nursery, and a four-unit premature nursery equipped with incubators piped with oxygen and a direct line to outside air. There are three delivery rooms, including one with an observation gallery. The walls of these rooms are finished in ceramic tile from floor to ceiling level, adequate locker and shower rooms for the doctors and nurses, and six labour beds complete

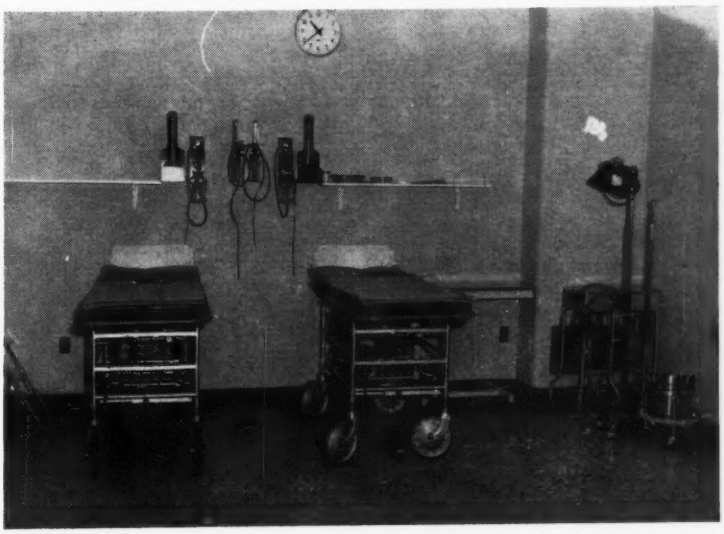
this wing. Patient accommodation is provided in the other two wings, one devoted to standard wards and one to semi- and private rooms. On both public and private wards—as on the medical and surgical wards which occupy the third and fourth floors—all beds are of variable height, while the room furnishings are of identical design, executed in different colours. Each room has an individual toilet and wash basin complete with bed-pan rack and flushing unit for pans. All beds are screened with curtains mounted on a ceiling-suspended track. Under-pillow radio loudspeakers equipped with a pull chain designed to provide a choice of four radio stations and a record turntable enables each patient to enjoy this medium of entertainment while hospitalized, without disturbing his neighbour. At the same time, the hospital can control one of our many noise problems by adjusting the volume from the master unit and by turning it off at a reasonable hour. In addition, there is a microphone arrangement at the master unit, over which a daily devotional program is broadcast, to the enjoyment of many of the patients. The nurses' call system is an audio-visual one so that the patient and nurse can converse while the nurse is at her station or in a service room, without the nurse taking unnecessary steps to the patients' bedside. As will be seen from the illustration, the nurses' station provides a clear view of two wings, enabling a strict visual control at all times. Service facilities include a dry-mop vacuum-system closet, flower rooms with adequate counter space and well cupboarded utility rooms including a refrigerated ice-holding unit, stainless steel counters, rubber goods drying closet and a large utensil sterilizer. Next door to this room is a patient examining room equipped with examining table, lamp and x-ray viewing box. In order to give the prospective fathers a little privacy, a separate waiting room furnished in authentic western motif adds a degree of charm, in addition to carrying forward the aim of decorating this hospital in warm, varied colours suitably matched with the furniture and the draw drapes which cover each window. In addition to this room there is a public waiting room on each floor tastefully furnished so that ambulant patients may visit with other patients and friends in a different atmosphere.

On the medical floor an inter-denominational chapel complete with organ provides a sanctuary for those who desire it. Religious services are also conducted here both for the staff and patients.

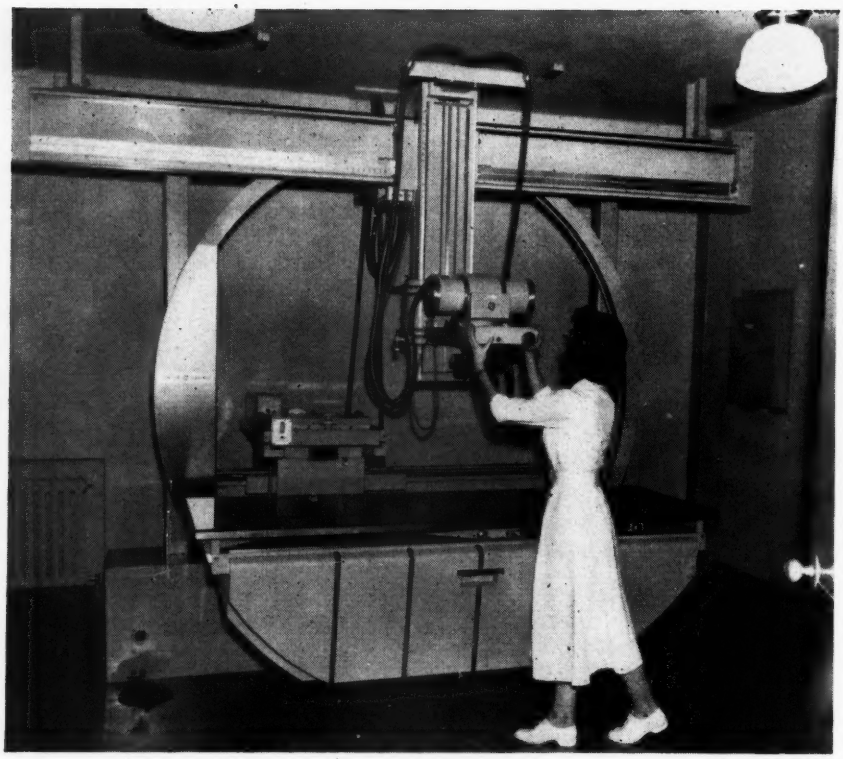
The fourth floor houses the surgical patients, as well as a separate wing

Orthopaedic room showing mobile plaster truck.

Central supply room, on fifth floor, showing "in" and "out" board for sterile trays.



Post-operative recovery room.



Diagnostic radiology room, showing 500 M.A. x-ray machine.

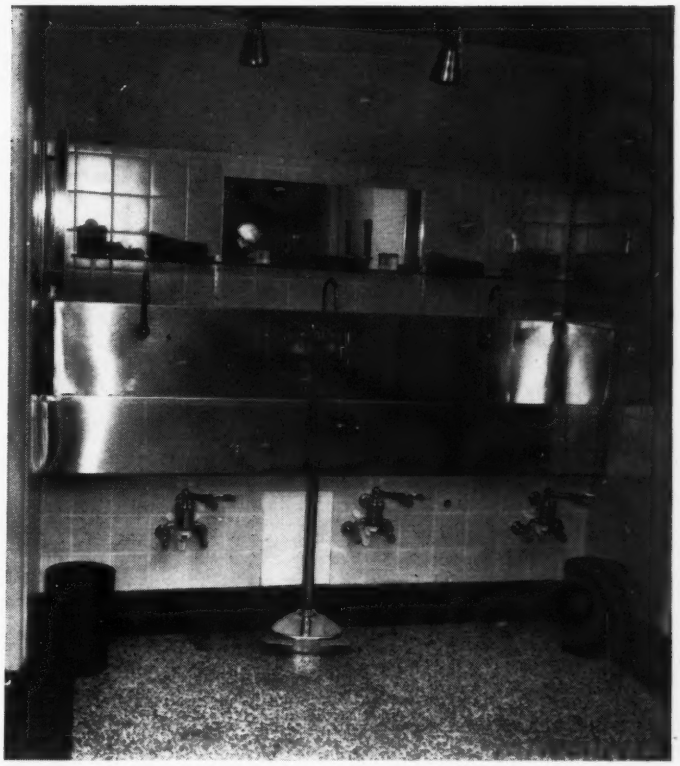
for paediatrics. This unit segregates infants in a four-bassinet cubicled ward, two four-crib individual cubicle units and a four-crib isolation unit, all divided with ceiling-height glass partitions so that the nursing personnel can maintain a continual watch over all the young ones. There are two larger units containing four beds each for older children, a small play room, examining room and admitting office so arranged that this department is practically an entity in itself.

Central oxygen and suction is provided for all beds on the medical, surgical and paediatric wards, and telephone jacks provide outside communication for all patients—a feature which has proved a comfort to many relatives in the winter months when transportation is difficult.

The fifth floor of the building is entirely devoted to operating rooms, central sterile supply and a recovery room. Adjacent to each operating room is an anaesthetic room where the patients are intubated under a more serene and less disturbing atmosphere than is generally present in an operating room. Safetv has again been the keyword in the design and equipping of this section of the building. There are three major operating rooms, one minor and cast room. The floors are of conductive oxychloride terrazzo, and the walls are tiled in everest green tile from floor to ceiling. The solution cabinets and instrument sterilizers are all recessed and are accessible from each individual room. Glass recessed shelving, recessed x-ray viewing boxes, and stainless steel equipment and utensils provide an easily cleaned and thus sterile working area. Culture plates taken systematically have shown a relatively low bacteria count. This factor together with a minimum incidence of post-operative infections leads one to believe that a properly equipped and designed building lends itself to easier housekeeping with maximum results. Humidity and temperature are controllable for each individual room both in summer and winter so that working conditions for both patient and operating personnel are maintained at constant levels. A small darkroom for developing x-ray films is centrally located on this floor, thereby saving much time since the x-ray department is located five floors below. In order to further serve the patients a 100 M.A. portable x-ray unit is located on this floor at all times. To take care of emergencies there is a signal system in each room which is audible in the supervisor's office, and also switches on a light over the door of each room. A signalling device which indicates any shorts in the sealed electrical circuit is a further safety precaution. The central supply room—which is well illustrated—provides all of the hospital with sterile trays and water. The water is distilled, flasked and autoclaved again in order to guarantee the patients' maximum safety. Labour-saving equipment, such as glove washers, driers, and powderers, syringe and needle washers, flask washers and thermometer shakers, do much to ease the work load in this very busy department. Adjacent to this department are two fire-proof anaesthetic gas storage rooms—both vented to the outside and equipped with vapour-proof light fixtures. The recovery room is of the open type so that the nursing personnel have easy access to all patients. An adjacent clean-up area is well equipped with sterilizer, bedpan flusher, and adequate cupboard space. Stretchers equipped with siderails are used for patients in this room. This technique has proved very satisfactory in that the patient is taken from the surgical ward on this stretcher to the pre-operative anaesthetic room. After the operation, the stretcher can then be wheeled into the operating room, thence to the recovery room and then back to the patient's ward. Wall-mounted suction oxygen, and sphygmomanometers, judiciously spaced, enable the staff to take care

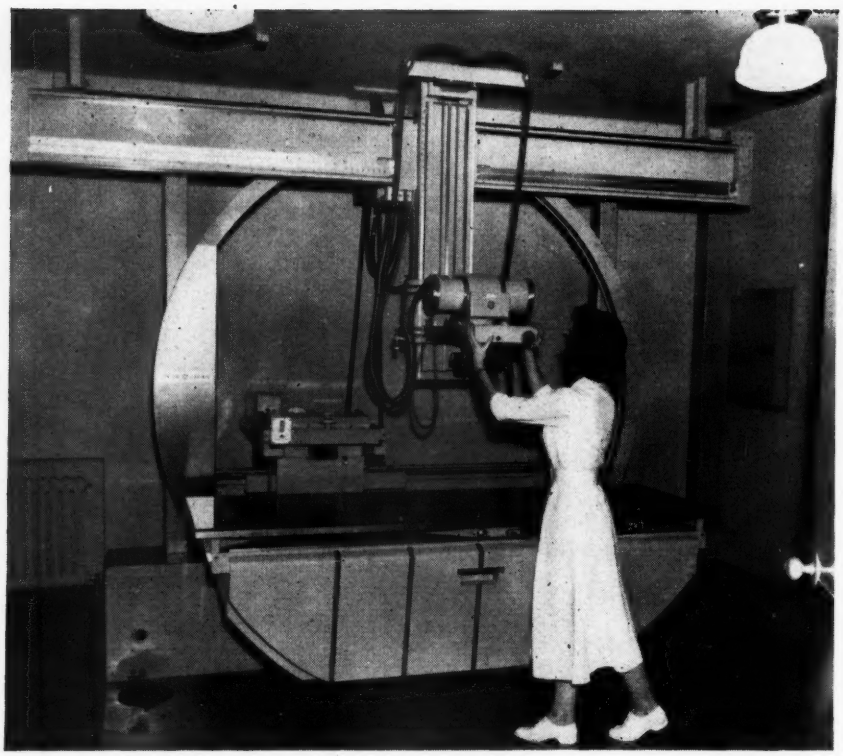
of maximum patient load in a minimum area. A small but well equipped dental room completes this area of the hospital.

The accompanying pictures may help to amplify this brief description of the many services and facilities available in this institution. However, without the use of colour it is difficult for one to envision the beauty both inside and out of this building. The terrazzo floors are in many shades of buff, red, maroon, green and black. The oak panelling, rubbed down to a beautiful golden oak shade, gives warmth to the board room and the main rotunda. Bright pastels on the cafeteria walls contrast with the gleaming stainless steel. Built-in lockers and dressers painted to harmonize with the wall colours and complemented with an endless variety of drapes on the windows of the patients' rooms give an added note of cheeriness. Adequate use of tile in many shades in bathrooms, service areas, case rooms and operating rooms, carries through the theme of bright cheery colour—but not at the expense of good housekeeping. The main entrance, faced in travertine and serpentine marble and surmounted with the hospital crest, lends a graceful dignity by day—and when floodlit at night appears as a beacon to those in distress. ●



***Surgeons' scrub sinks.** Doors on either side lead into major operating rooms.*

This is one of three major operating rooms with walls of eue rest green tile from floor to ceiling. Note the absence of windows.



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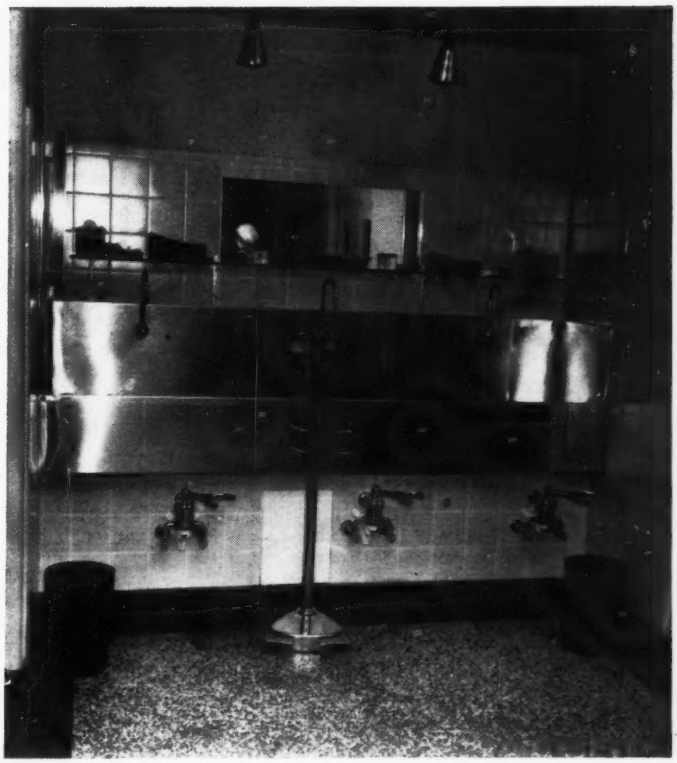

***Surgeons' scrub sinks.** Doors on either side lead into major operating rooms.*

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Canadian Educational Conference on

Current Administrative Problems

held by the A.C.H.A. in Toronto, May, 1956

Some 60 fellows, members, and nominees of the American College of Hospital Administrators, from six provinces and four states south of the border, attended an educational conference conducted by the College, at the King Edward Hotel, Toronto, April 30th to May 4th. The conference dealt with current administrative problems, under the general direction of Arthur J. Swanson, regent and president-elect of the College, Dean Conley, executive director, and Charles D. Skinner, assistant director.

Major Problem Areas

Preliminary consideration of major problem areas was led by four members of the group. W. A. Holland of Oshawa dealt with personnel and community relations and Dr. Arnold L. Swanson of Saskatoon with medical staff and related problems. Eugenie M. Stuart of the University of Toronto handled nursing problems, while financial problems were discussed by Stanley W. Martin of Toronto.

The conference was divided into three study groups for purposes of detailed discussion on the various problems introduced over a period of two days. Each group then presented its own conclusions for the consideration of the conference as a whole. Group reports were presented by the chairmen, Robert B. Ferguson of Toronto, Dr. L. O. Bradley of Calgary, and Max B. Wallace of Toronto.

Economic Trends

The significance of the general economy of the country, and of labour-management relations, to hospital administration was recognized by devoting a full day of the conference to these aspects of current administrative problems. Professors V. W. Bladen and Harry Eastman of the Department of Political Economy, University of Toronto, spoke respectively on "The Current Economic Picture" and "Future Developments in Public Finance". Professor H. D. Woods, director of the Industrial Relations Centre, McGill University, Montreal, addressed the group on "Trends in Labour-Management Relations".

Professor Bladen described changes in population, in the attitude towards government, and in the position of labour, as the three most important factors in our economy. To many of his listeners he gave the word "inflation" new significance in a discussion of the changes in Canada's national income (or gross national product) over the past quarter century. The development from 6.2 billion dollars in 1929 to 26.6 billion dollars in 1955 became progressively more meaningful as it was translated into terms of "1935-39 dollars" and was related to population figures. The first step produced a variation from 1929 to 1955 of from 5.3 to 13 billion. Relating the figures for national income to the population of the country resulted in a change from 1929 to 1955 of $530 to $830 per capita.

Playing what he described as a good (and harmless if not taken too seriously) indoor sport or parlour game, Professor Bladen proceeded to analyse the component parts of the national income for 1955 and to make forecasts

Gathered here, left to right: Eric R. Willcocks, Toronto; E. Carey Robinson, St. Catharines; Werner Daechsel, Kingston; Gladys M. Bayne, Morrisburg, formerly of Valhalla, N.Y.; Walter Hatch, Kitchener, Ont.; and R. Ray Copeland, Port Colborne, Ont.

of what was likely to occur in 1956. The net result of this forecasting was a prediction of a gross national income for 1956 of 28.8 billion, slightly higher than that predicted by the Minister of Finance, and, if this came to pass, it would probably result in a further increase in prices.

Professor Eastman traced the historical development of government spending from the pre-depression "balanced budget" philosophy to the current doctrine of heavy governmental expenditures, particularly in times of general economic recession. As Professor Bladen had previously indicated, he referred to the significance of government expenditures on national defence, stating that nearly 6½ per cent of the gross national product is channelled to defence purposes. Incidentally, in the United States this figure reaches approximately 10 per cent. He made reference to the increasing tendency of governments to assume fixed commitments, such as hospital maintenance grants, social security, et cetera. The assumption of responsibilities of this kind reduced a government's freedom of action and limited its ability to do other things. Nevertheless, governments were under constant pressure to assume even greater commitments, presumably as the result of greater numbers of people adhering to the philosophy that governments can do many things better for the people than the people can do for themselves.

Unionism among workers has increased tremendously in recent years and although the rate of increase is slowing down, the trend towards unionizing the non-unionized is likely to continue, stated Professor Woods in his address. Social class barriers are weakening and collective bargaining is becoming "respectable". This is made evident by the activities of such organizations as the Airline Pilots Association.

Following their lectures, Professors Bladen, Eastman, and Woods, led a very active two-hour discussion period, during which some 16 questions concerning everything from salaries and wages to the effect of health insurance were thoroughly discussed.

Communications

The final two days of the conference were devoted to human relations with particular emphasis on inter-communication.

Professor Oswald Hall of Tulane University, New Orleans, spoke on "The Social Context of Communication". John Sawatsky of the school of business administration at the University of Toronto presented "Goals of Communication." "Improving the Form and Content of Communication" was handled by Carl Williams of the department of psychology at the University of Toronto. Tom Mallinson of the Toronto Psychiatric Hospital discussed "Communications in the Hospital".

The concluding session of the conference was a panel discussion and question and answer period under the direction of the foregoing speakers—completing a highly successful conference.—*Murray W. Ross.*

Seated left to right: Mother Ste-Thérèse, Sorel, P.Q.; Sr. St. Paul, Brantford, Ont.; and Sr. Marie-Angèle, Ottawa.

Standing: Sr. Florence Mary, Kenora, Ont.; Sr. Mary Ruth, Vancouver, B.C.; and Sr. St. Philippe, Sudbury, Ont.

Enjoying coffee break, left to right: R. Fraser Armstrong, Kingston; Gaspard Massue, Montreal; Mrs. Dora Shrimpton, Toronto; Helen M. Yerger, Albion, N.Y.; Dean Conley, Chicago (Executive Director of the A.C.H.A.); and Lowell Swanson, Iron Mountain, Mich.

A group of delegates taken immediately following the business session of the New Brunswick section.

Fourteenth Annual Meeting of the

Maritime Hospital Association

THE fourteenth annual meeting of the Maritime Hospital Association was held at the Algonquin Hotel, St. Andrews by-the-Sea, May 29th, 30th and 31st. While delegates had to journey to the meeting through fog and damp weather, Tuesday was a bright, cloudless day, warm enough to promise that perhaps spring was finally here.

The official opening of the convention and exhibits was performed by Rupert H. Stocker, president of the Maritime Hospital Association. He reminded the delegates that the meeting was primarily concerned with the business of the association; an opportunity for delegates to visit exhibits, and between sessions to have a bit of relaxation.

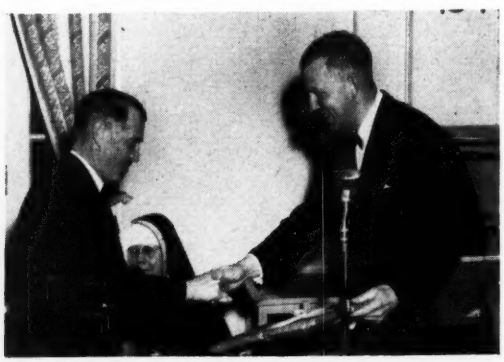
The convention followed the usual pattern of the previous meetings. Convening with the Maritime Hospital Association were the Maritime Hospital Auxiliaries Association and the Maritime Hospital Exhibitors Association. More than 350 delegates attended.

The First Day

Most of Tuesday was devoted to sectional meetings; the New Brunswick section met under the chairmanship of C. T. Ballantyne of St. Stephens; Dr. Hugh MacKay of New Glasgow was chairman of the Nova Scotia-Newfoundland section; and Col. Leo MacDonald of Charlottetown headed the Prince Edward Island group.

The executive of the Maritime Hospital Association had previously circulated to each section a report of a special committee appointed to study the possibility of a full-time secretariat for the Maritime association. In the business session, all sections decided that a full-time secretariat was not feasible because of the difficulty of financing such an office. The Nova Scotia and New Brunswick sections recommended, however, that part-time secretaries be appointed by those sections wishing to do so, in which case the Maritime Hospital Association would assess hospitals in the sections concerned regarding additional dues to cover the salary recommended by the particular section. Any necessary changes in existing by-laws of the as-

Dr. J. Gilbert Turner, president of the Canadian Hospital Association, is shown presenting Mother Ignatius, recipient of the George Findlay Stephens Memorial Award, with a landscape painting of Ross Ferry, Cape Breton. The painting is by Dr. Harvey Agnew, former executive secretary of the Canadian Hospital Council.



Mr. Stocker, president of the Maritime Hospital Association, is shown presenting an honorary life membership to Col. J. Lawrence Black, chairman of the association's arbitration committee. The honorary life membership was bestowed on Col. Black, the first in the history of the association, because of distinguished service rendered.

A group of delegates from Prince Edward Island: Mrs. C. E. Praught, Mr. C. E. Praught, Col. Leo. MacDonald, all of Charlottetown; John Ledgerwood, Summerside.

Group taken following the Blue Cross session. Left to right: J. A. Comeau, Meteghan River, N.S., who chaired the session; Mr. J. A. Brophy, town-clerk of Bridgewater, N.S.; James E. Stuart, executive director of the Hospital Care Corporation, Cincinnati, Ohio, who was the main speaker; Miss Ruth C. Wilson, Moncton, executive director, Maritime Hospital Service Association; and Mr. Ronald J. Mulcahey, of the Halifax office of the Maritime Hospital Service Association.

Mr. R. H. Stocker, administrator, Western Memorial Hospital, Corner Brook, Nfld., president of the Maritime Hospital Association; Mrs. Gladys Porter, Kentville, N.S., secretary-treasurer, Maritime Hospital Association; Dr. J. Gilbert Turner, president, and Dr. W. Douglas Piercey, executive director of the Canadian Hospital Association.

The new executive of the Maritime Hospital Association, taken immediately following their election. Front row: Mrs. Gladys Porter, Kentville, N.S., secretary-treasurer; Mr. Rupert H. Stocker, Corner Brook, Nfld., president; Miss Jeannie Murdoch, Sackville, N.B., voting member for professional nurses of the Maritimes. Back row: Dr. A. M. Clarke, Moncton, vice-president for New Brunswick; Mr. A. H. MacDonald, Glace Bay, N.S.; Dr. Hugh MacKay, New Glasgow, vice-president for Nova Scotia; Col. Leo. MacDonald, Charlottetown, vice-president for Prince Edward Island; Dr. E. Wilson, St. John's, vice-president for Newfoundland.

New executive of the New Brunswick section: Dr. A. M. Clarke, executive director, Moncton Hospital, chairman; Mother Saint-Georges, Vallée-Lourdes; Sister M. de Paul, St. Joseph's Hospital, Saint John; Dr. D. F. W. Porter, hospital consultant, Bathurst. (Absent when this picture was taken was Mr. Paul Berry, Moncton, secretary).

sociation were referred to the incoming executive. At a regular business meeting held on Tuesday, May 29th, the association approved a change in by-laws which permitted the creation of honorary life members.

The afternoon session of the New Brunswick section was chaired by Dr. A. M. Clarke of the Moncton Hospital. A resolution was passed requesting the continuation of federal construction grants after the present five-year period terminates in 1957. Dr. Carl R. Trask, superintendent of the Saint John General Hospital, stated that a recent salary revision in the Department of Veterans' Affairs meant that general hospitals would have to raise salaries in order to hold staff. Following discussion, the New Brunswick section passed a resolution which was forwarded to the Maritime Hospital Association asking that those hospitals with nursing schools be assisted financially by the Department of Veterans' Affairs.

Tuesday evening, after viewing a film entitled "From Pen to Plates" which showed an efficient method of admitting patients and portrayed the use of nursing station imprinters, the delegates enjoyed some lively entertainment through the courtesy of the Maritime Hospital Exhibitors Association. The entertainment was under the chairmanship of C. M. Carpenter, president of the exhibitors. Featured were the St. George, N.B., high school band conducted by William Suthers. Two barber shop quartets from the St. Stephen-Calais area also gave excellent renditions of several songs. Barbara Russell and Peter Atcheson of St. Stephen, two very young performers, entertained the delegates with popular numbers. Alex P. McGovern, of Halifax, a perennial stand-by with this type of entertainment, also played a leading role.

Wednesday and Thursday were given over to the presentation of papers and round table discussions. R. H. Stocker spoke on "In Preparation for a National Health Service" (see *The Canadian Hospital*, March, 1956, page 48); Dr. D. F. W. Porter, hospital consultant of Bathurst, N.B., presented a paper on "The Place of the Small Hospital in a National Health Service". Then came a panel discussion in which the following participated: Rev. Mother Saint-Georges, provincial bursar, les Religieuses Hospitalières de Saint-Joseph, Vallée-Lourdes, N.B., Dr. Gordon E. Wride, principal medical officer, National Health Grants, Department of National Health and Welfare, Ottawa, and Mr. H. Gordon Hughes, chief of the Hospital Design Division, Department of National Health and Welfare, Ottawa.

Blue Cross Session

Wednesday afternoon featured a Blue Cross session. Special speaker was James E. Stewart, executive director of Hospital Care Corporation, Cincinnati, Ohio. He presented an exeellent address on the philosophy of Blue Cross. The session was under the chairmanship of J. A. Comeau of Meteghan River, N.S. Mr. Mulcahey of the Halifax office of the Maritime Hospital Service Association and Mr. Brophy, secretary-treasurer of the Dawson Memorial Hospital, Bridgewater, N.S., spoke on various phases of Blue Cross in the Maritimes from the point of view of the carrier, the subscriber and the hospital. This was a very fine session and those responsible for the program are to be congratulated.

The Annual Dinner

A special feature of the annual convention dinner of Wednesday evening was the presentation to Mother Ignatius, Mother General of the Sisters of St. Martha, Antigonish, N.S., of the George Findlay Stephens Memorial Award. Dr. J. Gilbert Turner, president of the Canadian Hospital Association, outlined the history of the establishment of the award in honour of the late Dr. George Stephens, former president of the Canadian Hospital Council. Dr. Turner said: "The award we are about to make honours the name of one of the foremost hospital administrators of this continent. Dr. George Findlay Stephens was a graduate of McGill, where he was captain of the football team, served in World War I and then became superintendent of the Winnipeg General Hospital where he remained until 1940 when he went to the Royal Victoria. For six years during the very trying

Enjoying proceedings at the annual banquet are Sister Skidd, director of nursing, Chatham, N.B.; Sister St. Joseph, administrator, Edmunston; Sister Hackett, Chatham; Sister Audibert, bursar, Bathurst; Mother St. Albert, Regional Supervisor, San Pablo, Peru; and Sister Dufour, bursar, Edmunston.

time of World War II he was president of the Canadian Hospital Association. He was one of two Canadians who were elected president of the American Hospital Association and in 1946 that association honoured him with its Award of Merit. He helped found the Blue Cross in Manitoba and when he came to Montreal he was one of the co-founders of the Quebec Hospital Service Association. He died in Vancouver in the spring of 1948 about two years after his first illness and less than a year after his retirement from the Royal Victoria. So great was his influence upon the field that the directors of the Canadian Hospital Association saw fit to establish the George Findlay Stephens Memorial Award. Since its inception in 1949 seven men have been the recipients. The person we are honouring tonight is the first lady and the first Maritimer to receive the award. Within the past month I have had a letter from Mrs. Stephens saying how delighted she is that Mother Ignatius is the recipient this year and she sends her very best wishes to her."

The citation to Mother Ignatius was read by Dr. W. Douglas Piercey, executive director of the Canadian Hospital Association, and was presented to her by Dr. Turner. Along with the citation Dr. Turner presented Mother Ignatius with a beautiful landscape painting of Ross's Ferry in Cape Breton. The scene was painted by Dr. G. Harvey Agnew of Toronto, who was for almost twenty years executive secretary of the Canadian Hospital Council, and who had been actively associated with Mother Ignatius during the early years of the Council's activities. Mr. Stocker presented Mother Ignatius with a special gift on behalf of the Maritime Hospital Association, and Dr. J. A. MacDougall, chairman of the Maritime Hospital Service Association, presented her with a bouquet of roses as a token of the esteem in which Mother Ignatius is held by that organization.

For the first time in the history of the Maritime Hospital Association an honorary life membership of the association was conferred on Col. J. Laurence Black of Sackville, N.B. Col. Black has been chairman of the association's arbitration committee, a committee recently formed whose purpose is to settle on an amicable basis any differences between individual hospitals and the Maritime Hospital Service Association. Under Col. Black's leadership this committee has rendered an invaluable service.

Guest speaker at the dinner was Dr. J. Gilbert Turner, executive director of the Royal Victoria Hospital, Montreal, and president of the Canadian Hospital Association. Taking as his subject "What of the Future?", Dr. Turner reviewed the important trends occurring in hospitals today and in some thirty minutes gave the delegates a broad picture of hospital problems, and what they might reasonably expect in the way of important trends in the not-too-distant future.

On Thursday morning, Dr. W. Douglas Piercey spoke on "Public Relations in Our Hospitals". Evelyn Pepper, R. N., nursing consultant to National Defence Health Services, gave a very informative address on the topic, "Emergency Hospital Services in Civil Defence", and this was followed by a panel discussion, "Head Nurse Study". This panel was chaired by Janet Story, vice-president, Newfoundland Association of Registered Nurses. Others participating were: Dr. Edward Wilson, superintendent of the St. John's General Hospital, St. John's, Nfld.; Kathleen Harvey of Shelbourne, N.S.; Dr. C. M. Bethune, superintendent of the Victoria General Hospital, Halifax; Miss Pauline Laracy, Secretary of the Newfoundland nurses' association and Miss Jean Lynds of Newcastle, N.B. A round table discussion on hospital problems, conducted by Dr. Hugh MacKay of the Aberdeen Hospital, New Glasgow, wound up the session.

Resolutions Adopted

The following resolutions were adopted by the association:

BE IT RESOLVED that the Maritime Hospital Association forward a communication to the Honourable Minister of Veterans Affairs with a copy to the Honourable Minister of Health and Welfare stating that this organization respectfully requests that, since the Department of Veterans Affairs does not have training schools for nurses in its hospitals and recruits graduates from all the training schools in Canada, and further that they pay a schedule of salaries to nurses higher than private or municipal hospitals, consideration be given to provide a subsidy to schools of nursing in Canada. This reiterates a resolution passed last year and the committee recommends a further letter be sent to the Honourable Minister of Health and Welfare.

BE IT RESOLVED that consideration be given to the holding of the Maritime Hospital Association annual meetings in a more central location in order to be more convenient for the delegates.

BE IT RESOLVED that the Maritime Hospital Association recommend to the provincial governments that the official accounting system for all hospitals in the Maritime provinces be based on C.H.A.M.

BE IT RESOLVED that the Arbitration Board be continued to review and report on all applications for increased rates (if any) to Maritime Hospital Service Association by member hospitals for the year 1957.

BE IT RESOLVED that the thanks and appreciation of the Maritime Hospital Association be extended to: (a) The Maritime Hospital Exhibitors' Association for their continuing support; (b) All guest speakers and those taking part in the official program of the convention; (c) The departments of public health in the four Maritime provinces for their help and advice to the Association during the past year; (d) Management and staff of the Algonquin Hotel; and (e) The press.

Officers Elected

The following officers of the Maritime Hospital Association were elected: R. H. Stocker, president; Mrs. Gladys M. Porter, executive secretary-treasurer; New Brunswick section, Dr. A. M. Clarke, executive director of the Moncton City Hospital, chairman, Dr. D. F. W. Porter, Rev. Mother Saint-Georges, Bathurst, and Rev. Sister M. de Paul, St. Joseph's Hospital, Saint John, as members of the executive. Dr. H. F. MacKay, administrator of the Aberdeen Hospital, New Glasgow, was re-elected chairman of the Nova Scotia-Newfoundland section, F. H. Silversides, administrator, Children's Hospital, Halifax, as vice-chairman, and in addition, Robert Muir of Harbourville and John D. Mosher of Kentville were elected to the executive. The Prince Edward Island section elected Col. Leo MacDonald as chairman with J. E. Ledgerwood, administrator of the Prince County Hospital, as secretary. Executive members are Neil D. MacLean, administrator of the Prince Edward Island Hospital, Charlottetown, P.E.I., Judge S. T. Deroches of Montague, and Mrs. Mary Mooney, matron of the Souris Hospital.

Some 43 exhibitors, members of the Maritime Hospital Exhibitors Association, attended the convention and afforded delegates the opportunity of seeing the latest equipment available. As on previous occasions, the firms represented did much to make the convention a success. The support which they give to the Maritime Hospital Association is very much appreciated by delegates attending the convention and by the association as a whole.—*W.D.P.*

Perseverance is a great element of success. If you only knock long enough and loud enough at the gate, you are sure to wake up somebody. — *Henry W. Longfellow.*

For Trustees Only:

Keeping the Trustee Informed

James W. Mainguy,
Manager
Hospital Consultation and Inspection,
Hospital Insurance Service
Dept. of Health and Welfare,
Victoria, B.C.

THE majority of new members on any board or committee experience the same problem . . . finding the information needed to give them an understanding of their new responsibilities. This is especially true if they have had little experience in the particular field. However, whether experienced or not, all members have the problem of keeping up-to-date with current developments. Hospital trustees are no exception. They must establish the policies according to which the administrative staff of the hospital will function even though the detail of daily operation should be left to the administration. They are responsible for preserving the finances of the hospital. They must appoint the administrative staff. They also appoint the medical staff. Hospital trustees shoulder these heavy responsibilities but usually have only their spare time to devote to their position. Surely it is important, therefore, that every assistance be given to the new trustee and that all trustees be kept informed about the hospital's activities.

When all this is considered, it seems clear that a program for informing the new board member should be planned. This may seem self-evident—nevertheless many hospitals do not have any such systematic arrangement. Opinions may vary as to how this should be done. However, I feel that certain information would be common to any plan intended to acquaint the new trustee not only with the activities of the hospital but with the hospital field in general. The basic documents which should be given to the new trustee are the by-laws of the hospital, the by-laws of the medical staff, and the personnel policies of the hospital.

I am sure that a new member would also be interested in knowing something of the history of his hospital. If this is not written down, a member of the board or the administrator would be able to provide a brief outline. Some hospitals have a written history available for use by members of the hospital society, the board, and the employees.

A new trustee will benefit a great deal from a visit to the hospital to see its different departments in action and to have explained to him the way in which each department fits into the operation as a whole. A copy of the organization chart of the hospital would be a useful supplement to such visits.

Some hospitals large enough to have well-defined departments make a point of having department heads come to board meetings, on a planned schedule, to give brief reports on the functions and operations of their departments. All this is designed to help the trustee achieve a good understanding of the general operation of the hospital, which is essential if he is to assist in establishing effective policies. It is not expected, of course, that he become acquainted with every departmental detail.

The new trustee would be interested in having a copy of the provincial statute governing hospital operation and the regulations under the statute. In British Columbia this statute is the Hospital Act. In this province, the emphasis in the Hospital Act Regulations is on the appointment and organization of a medical staff and on the functions of such a staff. It is probably this aspect of his trust which is least familiar to the new trustee. After he has had a chance to study these documents the new trustee would be well advised to read general literature on the subject of the modern hospital. It is not my purpose to make hard and fast suggestions as to what literature should be made available, but a few examples might help.

The book, *Small Community Hospitals,* by Southmayd and Smith, is an interesting introduction to the field. As the title suggests, it describes the small hospital, yet many of the points mentioned apply to hospitals of all sizes. Raymond P. Sloan's book, *This Hospital Business of Ours,* was written especially for the hospital trustee and is well worth reading. The pamphlet *The Board's Control of Hospital Medical Care,* published by the American Hospital Association, provides much to reflect upon. This pamphlet was adapted from a series of articles which appeared some years ago in *Trustee* magazine. There are also interesting articles which can be obtained. One such article: "The Trustee's Responsibilities in a Small Rural Hospital," by Hon. J. M. George, Q.C., which appeared in the magazine *Trustee,* August, 1953, would be helpful. "Training for Trusteeship," by John M. Storm, published in *Canadian Hospital,* in December, 1951, covers many problems of trusteeship. Another, entitled "The Business of Being a Trustee" by Curtis McGraw, appeared in *Hospitals* in January, 1953. There are many others. All the information in these publications will not apply to any particular hospital, to any province, or, for that matter, to Canada. The reader will find that viewpoints expressed in some conflict with those in others. However, such material will help to provide necessary background information. If not available at the hospital, it is usually possible to obtain this literature from the libraries of the Canadian Hospital Association or the American Hospital Association.

The transcripts of the proceedings of provincial hospital association meetings provide the trustee with interesting information which may be applicable to his own province.

I am not suggesting that the new trustee be burdened with all this literature at once; any one work would serve as an introduction.

In some provinces, there will be other material which should be added to the list. For example, in British Columbia, the Hospital Insurance Act and Regulations should be placed at the disposal of the trustee as well as such circulars as those dealing with construction and equipment grants and B.C.H.I.S. budget policies.

Even when the new board member has become acquainted with his hospital, and with the hospital field in general, he must still be kept up-to-date. A solution to this problem should also be included in the program.

For general reading, a subscription to the magazine *Trustee* is suggested. As a rule, its articles are applicable to Canadian hospitals. They are interesting and brief. Many administrators make a point of circulating amongst board members interesting articles from current hospital journals.

So far, I have dealt with information of general interest because we receive most questions upon material of this type. I believe that it is information of this nature which is most often neglected.

In contrast, it would be unusual to find a hospital where the board does not get a monthly financial statement. Often, however, the trustees see the

(Concluded on page 94)

A Medical Challenge to the Social Sciences

Part II

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THE following comments are based primarily on studies conducted in four hospitals: the Hartford Hospital, Hartford, Conn., by Alfred Wessen; the Veterans Administration Hospital, Roanoke, Va., by Earl Rubington; the Boston Psychopathic Hospital, Boston, Mass., by Drs. Greenblatt, York, and Brown; and the New York City Hospital, by this author. Although space will not permit a detailed account of our experiences and observations, certain tentative findings can be summarized in a few words.

1. The modern hospital, as an institution, has created for itself a culture that is in sharp contrast to the culture of the general community which it serves. This appears to be especially true of the large and long-established hospitals. For those of us outside looking in, and in some degree for those inside looking out, the threshold of the hospital has become a significant dividing line between two different ways of life. To cross over from one to the other, after a long stay in either, is something like entering a new culture with different sets of norms, values, conventions, routines, prescribed practices, and standards of performance.

In a hospital, the contrast between principles of democracy on the outside with those of the autocracy on the inside is enough in itself to jolt some of us out of our accustomed habits of thought, action, and feeling. If we cross the threshold as patients, even our natural bodily functions are expected to make quick adaptations to new routines. Decisions are taken largely out of our hands; and it is quite imperative that we become as soon as possible "to the manner and the role bred". The patient and his relatives, of course, generally cross over into the newly and highly charged culture under conditions of more than usual vulnerability.

The cultural formulations are very revealing here; and there is a great challenge for thorough study and analysis of hospital culture in contrast to the social milieu within which it exists.

2. A second surprising observation, especially to those bred in the concepts of the social sciences, is the wide-spread practice of placing the blame on persons for failure in expected performance. There appear to be the sharpest contrasts between efforts to understand and adjust to, or make allowance for, a badly behaving heart or other organ of the body and efforts to do the same for a person who has misbehaved.

Of all categories of hospital personnel, it would seem that the nurses excel in their almost continuous fear or dread of being singled out with an accusing finger. They also appear to be adept at pinning on blame, not infrequently on the patients. One nurse reported of a patient, "He was uncooperative, even on the day of his death". Well! Physicians and other staff members, however, are far from free of this quality when it comes to the behaviour of persons instead of organs. Indeed, it seems difficult to find hospital personnel who can look upon inter-personal behaviour with the same detachment and scientific perspective that they bring to physical phenomena. Would it be reasonable to expect that before an objective and systematic approach can prevail in the problems of inter-personal reactions in illness and therapy, as it exists in the hospital, it will be necessary for the key personnel to free their minds of the animistic, folklorish habits of blame and recrimination? I think it a prime necessity.

3. Our third finding came as even more of a surprise to us. The hospital is not a simon-pure institution in the sense that has been described above. To be sure, it claims to be such in name, in the appearance that it makes before the public, in the official announcements of its charter of purposes and policies, and above all, in the minds of its public relations personnel. Also, to the patients and their relatives who enter the front door, more or less under surveillance, it seems like a single and formidable institution.

A studied conclusion to date, however, is that the modern hospital is, in fact, a rather loosely knit, flexible, and changing aggregate of several institutions or sub-institutions which actually possess and try to operate under different and often conflicting charters. These sub-charter differences can manifest themselves in sharp cleavages between different sets of categories of personnel, with the main loyalties linked to the sub-charted principles rather than to the over-all and publicized ones.

Thus, in the light of the general and front-office charter, the behaviour of a particular person may appear either incomprehensible or contemptible or both; but in the light of the sub-charter to which the individual subscribes intellectually and emotionally, it may be easily understood and attributed to superior loyalty. These sharp cleavages may exist, for example, along perpendicular and horizontal lines. The perpendicular cleavages cut down between administration, medical services, and the nursing services. There are also sharp inter-departmental differences, such as between surgery and psychiatry. On the horizontal axis, as one looks across the hospital system, charter differences are also marked off, somewhat like the lines in a layer cake, and with corresponding loyalties to different charter strata.

This criss-cross of charter cleavages catches almost every individual in the system, marks him, usually with a uniform, and sets in operation forces within the structure and through the culture of the hospital to influence his ways of thinking, feeling, and behaving. A simplified formula for much of the behaviour observed in him could be expressed and better understood as role performance to sub-charter commitments. This concept of the intervening or sub-charter commitments appears indispensable to us for a systematic and objective study of interaction patterns in hospital practice.

4. The fourth finding is no surprise at all to those trained in modern social science concepts. It is the need to discriminate systematically between the formalized and prescribed patterns of interaction and the informal patterns which arise and grow up out of the experience of daily practice. It is easy to observe that in the hospital, as elsewhere, these informal, conventionalized commitments and prescriptions for getting on with others and

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This article is from an address delivered to students in hospital administration at the University of Toronto, February, 1956.

getting the job done can be identified and classified with substantial precision and that they are very revealing in the explanations of human behaviour, especially in structured relationships. This is essentially the refined cultural approach of our modern anthropologists.

Perhaps the phenomenon of the informal cultural pattern should be illustrated out of familiar hospital experiences. A physician was one day observed painstakingly showing a medical student each formalized step in a complicated gynaecological procedure. A few days later the student was watching the physician in his clinical practice. The relationship between the two was "informal" enough that before long the student said to the physician, out of earshot of the patient: "Sir, you did not do that as you have told me to do it". "That's right", the physician answered, "but until you have learned thoroughly the formal way, you had better not try the informal". In a talk with the head nurse later, the student remarked cryptically, "The top doctors do just about as they please!"

She was, of course, mistaken. The "top doctors" are experienced and smart enough to resort to informal patterns, which are almost as clearly prescribed or conventionalized, but much more difficult to learn and operate wisely unless they have developed out of long experience.

It would be instructive to report Dr. Earl Rubington's study of the effects of the informal patterns of behaviour in an instance of carefully planned and "directed culture change" in a veterans' hospital for the mentally ill. A 75-hour training program was provided by the nursing staff for orderlies in order to make them into "psychiatric aides" somewhat skilled in progressive and what is sometimes called "comprehensive" therapy. The advantage appeared to be in favour of all concerned, including the aides. But they did not respond as expected and, indeed, resisted the program to an impressive degree. Why?

Dr. Rubington went to live with the aides for more than a year, worked along with them, and endeavoured to learn as fully as possible the reason for the resistance. He found it primarily in the informal patterns of conduct that seemed to determine their responses. His guiding concept was that the organized social behaviour of the aides in their work roles constituted an identifiable subculture pattern which, however informal and unofficial, carried considerable weight in the determination of their behaviour. It was his theory that their informal subculture constituted their solutions to the problems faced by them daily in the exercise of their duties. In order to understand these informal, and perhaps compelling, patterns of performance, he saw the need to analyze "the unique social conditions" under which the aides worked, the ways they interpreted these conditions to one another, and their conventionalized adaptations to them.

He found five critical factors that were viewed as major problems by the aides:

(a) low prestige

(b) mobility-blockage

(c) frequent association with deviants

(d) domination by females

(e) "subjection" to "directed culture change" in the occupational roles.

He then attempted to analyze the "culture pattern" of their work roles more precisely in terms of their informal solutions to these problems. He was able to observe in this informal culture pattern by which they operated, especially in the crisis situations, four analytical variables:

(a) skills for dealing with their specific assignments;

(b) their normative rules for adjusting to the social situations;

(c) self-image as their "stable point of inner reference"; and

(d) their ideology concerning their functions as a "stable outer frame of reference for them".

Only part of the data on the latter two variables will be reported here in order to illustrate the force of the informal subculture dynamics in membership behaviour and, for our purposes, the order of the last two will be reversed.

The aides' ideology, how they viewed their functions in the hospital system, constituted, of course, their informal but active charter. It explained their functions to themselves as well as suggesting and justifying their behaviour. Here significant differences appeared as contrasted with the official hospital charter.

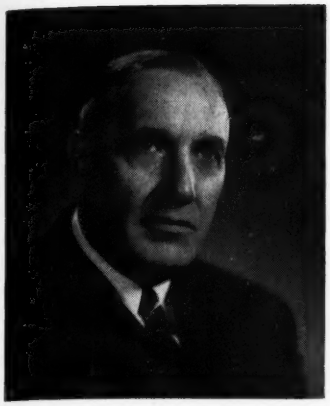
To begin with, the order of priorities in services to patients, as proposed by the official charter, was reversed. While the official charter held that the functions in patient services are cure, care, custody, and control (in the order named), the aides held in their thinking this order: control, custody, care, and cure. The teachers had considerable difficulty with this reverse order of priorities.

Reversals were also observed in other areas of ideology. The aides over-rated practical experience and under-rated theory and "schooling". Their concept of the model patient was not of the patient who took an active interest in his therapy and who sought maximum advantages in the opportunities for improvement and early discharge, but the patient who cooperated most fully with them in the problems of control and custody or who sat quietly in a corner day after day. While the nursing staff tried to teach the view that all patients are "sick", the older and "experienced" aides showed frank discrimination in their "diagnosis" of the sick, the crazy, and the just plain "mean".

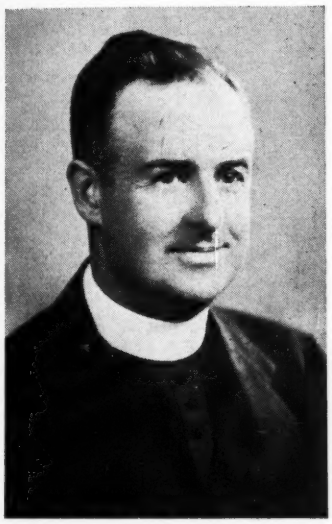
Being permanently of low rank, without power, subject to restricted communication with professionals, and under female dominance in a society that stresses masculine dominance, the aides' ideology was filled with conventionalized expressions of "status protest". And since maximum efforts served little to advance an aide's status or power, his informal policy supported minimum efforts. There was, also, free informal expression of the idea among the aides that since security with the superiors came primarily through compliance, it was good sense to refuse to "stick out one's neck", to be careful to ask the fewest, the simplest, and the most necessary questions, to keep formal contacts with the superiors, especially with the nurses, at a minimum, and to do nothing more than one was specifically instructed to do. The aides' ideology held further that in the ward emergencies the main loyalties come from fellow aides instead of from the superiors.

With such customary and routine thinking, shaped and shared out of the practical or problem-faced situations, let us look briefly at the aide's stereotyped self-image, his "stable point of inner reference". Confronted on the one hand by an atmosphere of unpredictable violence from patients and on the other hand by female dominance, a very high value was placed on masculinity in the aide's subculture. The masculine model was further enhanced for the aide by temptations or threats of sexual overtures from male patients, and by the conventionalized sexual connotations associated with the "male nurse". Thus, in fantasy and in practice, compensatory patterns had built up and idolized for the aide the self-image of a "man among men" who is able at all times to manifest tough personality traits and hard techniques.

With a more complete report of this study, including similar analyses of the aides' informal skills for specific assignments in control and custody and their normative rules for solving interpersonal problems linked with the hierarchy of the hospital system, it would become even easier to comprehend, perhaps to predict and alter, some of the behaviour of the aides that had



A. J. Swanson, chairman



Rt. Rev. John G. Fullerton, D.P.

Ontario Hospital Services Commission

Three members of Ontario's new Hospital Services Commission have been appointed. (See *The Canadian Hospital,* June, page 33.) Chairman is Arthur J. Swanson, general superintendent of the Toronto Western Hospital and executive treasurer of the Ontario Hospital Association which sponsors the Blue Cross Hospital Plan. (In order to assume his new post, Mr. Swanson has resigned the latter positions.)

The other appointees are: Rt. Rev. John G. Fullerton, chairman of the board of governors of Toronto's St. Joseph's Hospital; and Dr. John B. Neilson, superintendent of Hamilton's General Hospital.

The Hospital Services Commission, which is being established under authority of legislation passed during the recent session, may consist of between three and seven members. Legislation setting up the Commission has assigned it a program of great scope and given it wide authority to implement this program which includes the following:

Development in this province of a balanced and integrated system of hospitals and related health facilities;

Administration of any system of hospital care insurance, including diagnostic services, out-patient services and home care services which may be established by the Lieutenant-Governor-in-Council;

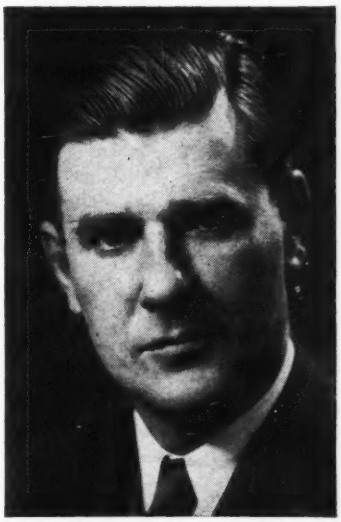
Control over distribution of capital grants for hospital construction, and over payments made to hospitals under any hospital care insurance plan which may be established;

Control over establishment of new and additional hospital facilities;

Establishment and operation of institutes and centres for the training of personnel for hospitals and related services;

Conducting of surveys and research programs;

Additional functions and duties as may be assigned to it by the Lieutenant-Governor-in-Council. — *Ontario Government Services.*



Dr. J. B. Neilson

been regarded as enigmatic or distinctly blameworthy. In organized group relations, in short, we have only begun to explore the possibilities of insight and knowledge that may be attained through thorough and systematic studies of the substructure and the subculture of human behaviour.

5. A fifth finding of special importance in hospital practice is the apparent discrepancy that exists between the charter commitments and the actual performance. Some of this discrepancy can be attributed to the gap that always exists between expressed ideals and practical realities. Moreover, because of their vested interests and resulting bias, the chief participants are often poorly qualified to make an objective appraisal on how well the results fulfill the promises.

A more pertinent observation for us, however, is that the sub-charter conflicts increase greatly the discrepancy that may exist between over-all charter claims and the possibilities for performance by particular sub-categories of personnel. It is conceivable, for example, that the charter standards and objectives of performance in the medical profession may require of the operating personnel, in a given hospital, levels of accomplishment that are entirely unobtainable and thus make for the practicing physicians obvious and predictable frustrations and maladaptations.

Another example can be found in the experience of our more recent graduates in the leading American schools of nursing. These young women acquire concepts of patient care, principles of practice, and standards of performance that are so much superior to and out of line with the existing norms and conventions of the hospital of today that they are bound to be confronted with frustrations, discouragements, and the necessity for sharp compromises. In a sense it could be said that there is nothing mysterious or blameworthy about this at all —they are simply caught for the time in the built-in "booby traps" of the system. On the other hand, to gain a certain amount of insight and perspective may serve to free their minds of self-blame or recriminative responses toward others and perhaps pave the way for more constructive compromises or substantial progress.

6. A last question to introduce here concerning institutional dynamics, or determinants of behaviour, lies in the concept of formal vs. informal patterns and pressures for compliance within the institutional setting. A perplexing experience for the administrator and

(Continued on page 72)

Provincial Notes

New Brunswick

AMHERST. It has been announced that a new obstetrical unit for Highland View Hospital is near completion. The unit will contain more than 14 beds and furnishings will be provided by the Ladies' Hospital Aid.

NEWCASTLE. The Miramichi Hospital has announced that an elevator to honour the memory of Allan A. Davidson (a descendant of William Davidson, one of the first English-speaking settlers in the Miramichi district in 1765) has been donated to the hospital by Lord Beaverbrook. The new elevator will replace the present unenclosed one, and will cost about $17,000.

SAINT JOHN. Work on the new St. Joseph's Hospital building is advancing rapidly. Erection of structural steel and the pouring of concrete for the walls and upper floors is in progress. The $3,200,000 project is scheduled to be completed next year, when the present hospital will become a combined nursing school and nurses' residence.

SAINT JOHN. Contracts have been awarded by the Board of Commissioners of the General Hospital to speed up construction work in the hospital's $4,000,000 expansion program. They include a contract for $256,000 worth of steel for the new wing. The powerhouse that will serve the entire hospital was opened last fall; and the $900,000 diet kitchens are half finished.

SAINT JOHN. The new $804,000 nurses' residence at the General Hospital, the second stage in the new hospital plan, providing 118 additional beds for nurses-in-training was opened recently. A main lounge occupies an entire section of the south wing of the building and contains a huge brick fireplace and south wall with folding doors concealing the gymnasium.

Quebec

MONTREAL. At a recent ceremony the Hon. Paul Sauve, Minister of Social Welfare and of Youth, laid the corner-stone of the new $10,250,000 Montreal Children's Hospital. The new building is an addition to the former Western Division, Montreal General Hospital.

QUEBEC. The new $4,000,000 Jeffery Hale's Hospital, looking towards the Laurentians from its site upon a promontory, has been officially opened by Premier Duplessis. The hospital has a capacity of 150 beds, which can easily be expanded to 200. It was announced that the provincial government had made grants totalling almost half of the cost. This institution owes its origin to a local philanthropist — an old naval captain, Jeffery Hale, who bequeathed the sum of $9,000 towards the foundation of a hospital for English sailors.

TROIS-RIVIERES. The official opening of the new extension to l'Hôpital Sainte-Marie will take place during the summer, although many sections of the building are already in use. The new building will provide 180 beds (for men and women)—almost tripling the accommodation provided by the original building—50 beds for unmarried mothers, and 228 beds for infants and children.

Ontario

BROCKVILLE. Urged on by shortage of patient accommodation, the first half of the projected $580,000 addition to St. Vincent de Paul hospital has been commenced. The Sisters of Providence, who operate the hospital, have underwritten the expense while government assistance is awaited. The addition will provide 55 active treatment beds and 18 bassinets. The first section to be built will be the north half of the new wing; after the completion of this unit, the present east wing of the hospital will be torn down and the south half of the expansion will proceed.

CHATHAM. A new wing of the Chatham Public General Hospital has been opened recently but, due to lack of funds, it has not so far been possible to complete the five floors planned in 1952. Only two floors are ready for occupancy and use. Thus, 50 beds have been added to the present accommodation — making a total capacity of some 225 beds. Estimated costs for the completion of the proposed basement, third and fourth floors are $714,000.

OAKVILLE. The $1,767,545 four-storey addition to the Oakville-Trafalgar Memorial Hospital was officially opened recently by Premier Leslie Frost, thus bringing the capacity of the institution to 177 beds. The Atkinson Charitable Foundation made a grant of $25,000 towards the $28,000 difference between 1954 estimates for furnishings and 1956 prices. A staff of 300 will operate the new hospital, the exterior of which has a unique pale green front wall of glass and aluminum.

OTTAWA. The Ontario Cancer Treatment and Research Foundation, Ottawa Civic Hospital Clinic, recently opened an addition which houses the new Cobalt 60 Beam Unit. The building was provided through funds donated by the Lions Club of Ottawa and the Cobalt Unit, which weighs some seven tons, was supplied by the Foundation.

OTTAWA. The trustees have announced a revised plan for the Civic Hospital's $3,200,000 expansion policy. The new plan is to build a four-storey wing to the east of the pathology building and another four-storey structure that will link both these buildings with the existing east wing. This will add 300 beds, improved services, and an estimated 7,000 square feet of floor space for future changes.

SOUTHAMPTON. The Board of Trustees of the Saugeen Memorial Hospital have announced that construction is expected to start late this summer on the addition to the hospital to provide 12 more beds and additional services. Increasing costs have changed the original estimate of $80,000 to $145,000.

TORONTO. Health Minister Phillips used a power shovel to turn the first sod at the site of the Salvation Army's new Grace Hospital at Church and Hayden Sts. The L-shaped maternity hospital of six storeys will cost $1,600,000. It will comprise 113 beds, 88 nursery cots, and 20 delivery rooms. It will be one of a chain of the Salvation Army's 14 hospitals, together with 16 homes for unmarried mothers, across Canada. On completion, the present Bloor St. hospital will be used as a nurses' residence.

WINDSOR. The recently opened $500,000 psychiatric and physical medicine wing of the Metropolitan General Hospital allows the addition of 31 general hospital beds, and boosts the capacity of the hospital to 350. The first floor provides for the accommodation of 30 psychiatric patients who will be under treatment by staff and social workers.

Manitoba

CRYSTAL CITY. The Hon. R. W. Bend, Minister of Health and Public Welfare, was present at the official opening of the new hospital, on which work was begun almost exactly one year ago. The new wards have been occupied by patients since the beginning of this year, and renovation of the second floor of the old building for staff residence has been completed. The institution has 18 beds.

WINNIPEG. One unit of the new nurses' home at Misericordia General Hospital, an auditorium-gymnasium, was opened recently. A swimming pool is also already in use. The remainder of the residence is due to be completed in about two years, after the rest of the hospital's building program is finished and patients transferred.

Saskatchewan

ESTEVAN. The new 25-bed and additional service wing to St. Joseph's General Hospital was recently opened by Premier T. C. Douglas. Costing $400,000, the wing brings the total capacity to 75 beds. Of striking modernistic design, the building features such improvements as a central oxygen supply source and a lead-lined x-ray control centre.

GULL LAKE. A government grant of $12,000 has been approved to assist the Gull Lake Union Hospital Board to construct a 12-bed unit. There will also be provision for another bed for maternity cases, five nursing cubicles, and a 740-square-foot area for outpatient treatment.

MOOSE JAW. A new hospital wing—to be called the Memorial Wing of the Moose Jaw Union Hospital — costing close to $2 million was officially opened by the Hon. W. J. Patterson, lieutenant-governor of Saskatchewan. It consists of six regular floors, basement, and sub-basement below and equipment penthouse at the top; it is of reinforced concrete with brick veneer construction and, with its provision for 129 beds, brings the total capacity to 218. Servicing equipment includes dust traps on each floor into which the dust that is brushed up is deposited and blown by air currents down to the sub-basement and garbage destroyer.

Alberta

CALGARY: The new $1,800,000 nurses' residence at the Calgary General Hospital will accommodate 304 students, each with a room of her own. The rooms will be decorated in six basic colour schemes; other features will include a basement "pyjama lounge", a recreation room with a giant checker board built into the middle of the floor, and individual mail boxes.

COLD LAKE. A contract for a $196,396 addition to the Cold Lake military hospital has been awarded to Bennet and White Alberta Ltd. Providing 25 beds, present capacity will be doubled. The two new wings, upon which construction has begun, will be of frame material with concrete slabs.

MEDICINE HAT. Voters have approved a $400 000 money by-law to construct an additional floor to the municipal district hospital now being built. The additional sixth floor will provide 60 more beds and raise the total to 256.

WAINWRIGHT. The hospital board has recommended that a new wing be constructed as soon as possible. Early plans indicate that a new maternity wing with all the required facilities may be built; and that better accommodation for children and staff will be provided. In the past, service has been provided for more people than population figures for the hospital district would indicate. It is hoped to begin construction in the late summer, subject to ratepayers' approval.

British Columbia

VANCOUVER. Southpines Convalescent Home, designed by Polson and Siddall of Vancouver, is in an initial stage of construction which will provide accommodation for 34 patients, at a cost of $85,000. The proposed addition of two 100-foot wings will bring total accommodation to 96 beds. Included will be eight private suites, each with self-contained toilet facilities. Dr. H. G. Weaver heads the medical group backing the project.

VANCOUVER. A $90,000 construction program is in its final stages at the Houghton Private Hospital. A new addition of 14 beds, the creation of large, bright wards in the original structure, and the installation of modern kitchen equipment have been under the general direction of architect William Noppe of Vancouver. Private funds have financed improvements that have brought the total number of beds to 32 which, as previously, will care entirely for Workmen's Compensation Board orthopaedic cases.

Hospitals Get Grants for Cancer

The indigent cancer patient today is getting the same care as the one who can afford the most expensive treatments, according to Dr. George Strean, gynaecologist and obstetrician-in-chief at the Jewish General Hospital in Montreal. Addressing 500 canvassers of the Cancer Aid League of Montreal who were being honoured at the closing campaign dinner, at which grants totalling $10,000 were distributed to representatives of six local hospitals, Dr. Strean said that in many cases the care being rendered poor cancer patients is better than the treatment accorded wealthier ones. He said that because several doctors are called in for consultations in welfare cases, the cancer patient has the advantage of a more detailed diagnosis.

The league has distributed welfare grants totalling $75,000 since its inception in 1954. It is an organization which works exclusively at aiding cancer patients who are unable to pay for hospitalization, medication and treatment. Honorary Life President Mrs. Sidney Nemtin said the league plans to contribute an additional $70,000 before the end of the year.

Tangible Progress in Civil Defence

Ottawa has decided to buy 500 mobile emergency hospital units, starting this year with a first batch of 25. The hospitals, costing $20,000 each, will have 200 beds, and will presumably be on the lines of the army's effective wartime field hospitals. They will have an obvious value in cases of major non-military disaster.

Anybody who suddenly wants to bury the hatchet probably has an axe to grind.

From the

Report of the Secretary-Treasurer

to the

Maritime Hospital Association

THREE regular meetings of the executive were held during the year, one in Charlottetown following the 1955 annual meeting, and two in Moncton in October and March.

Early in 1956 we held a most successful institute for hospital accountants, administrators, and office personnel, under the very capable direction of Mr. Walter W. B. Dick. We had spendid support from our several provincial governments and received many favourable comments regarding the benefits derived by those in attendance. Speakers from outside the province were Stuart K. Hummel, Milwaukee, Wisconsin, representing the American Hospital Association; Murray W. Ross, Toronto, representing the Canadian Hospital Association; Paul D. Shannon, C.A., Royal Victoria Hospital, Montreal; and Fraser Harris, from the Dominion Bureau of Statistics, Ottawa, all of whom lent valuable assistance as did the executive and staff of the Maritime Hospital Service Association, the staff of Hudson, McMackin and Company, and representatives of our own association.

Sectional groups have been very busy during the year, giving special attention to the proposed national health plan. In New Brunswick the advisory committee has met several times with their Department of Health committee and is acting in a truly advisory capacity to that body. Dr. Hugh MacKay has been appointed representative of the Nova Scotia section on the Nova Scotia planning committee; Sister Catherine Gerard is a member representing the nursing profession. Both have been very active. Your secretary-treasurer has been appointed by a committee from the Union of Nova Scotia Municipalities to present a brief on behalf of that body. In Prince Edward Island, our executive members report much time has been spent in conference with the P.E.I. committee and in Newfoundland our president and our executive member, Dr. Edward Wilson, are available for conference with their Department of Health.

We are pleased to welcome to our Maritime Hospital Association family the Victoria Memorial Hospital, Baddeck, N.S., formerly a Red Cross Hospital and now operated by the community. We are pleased also that the St. Clare's Mercy Hospital, St. John's, Nfld., has now become a member and that Sr. Mary Fabian is in attendance. We welcome also as a new "individual" member from New Brunswick, Mother Saint-Georges.

Our arbitration committee — in connection with Maritime Hospital Association-Maritime Hospital Service Association relations — has done very fine work. We are pleased that the chairman, Col. J. L. Black, is with us and to Col. Black, Mr. W. R. Fiske, and Mr. P. M. Blanchet, go our sincere thanks.

We are grateful to the executives of our allied associations, Dr. J. A. MacDougall, Ruth Wilson, W. R. Fiske, and the many others of the Blue Cross; to Walter Dick who, as usual, was responsible for an outstanding institute; Mrs. Gordon Leitch and others of the executive of the Maritime Hospital Aids Association; Mr. C. M. Carpenter and his associates of the Maritime Hospital Exhibitors Association, whose firms have displays in the usual number of booths at this meeting; to Elizabeth Summers and her nursing committee; the committee set up to study the matter of a secretariat; executive and staff of the Canadian Hospital Association; government representatives, and national and provincial departments of health, and the very many others assisting us generously at all times.

To the president, Mr. Stocker, and members of our own executive, we extend our grateful thanks for the long hours they have put in on our behalf and their unceasing efforts for the general betterment of our Maritime hospitals. — *Gladys M. Porter.*

West Kootenay Regional Hospitals Council

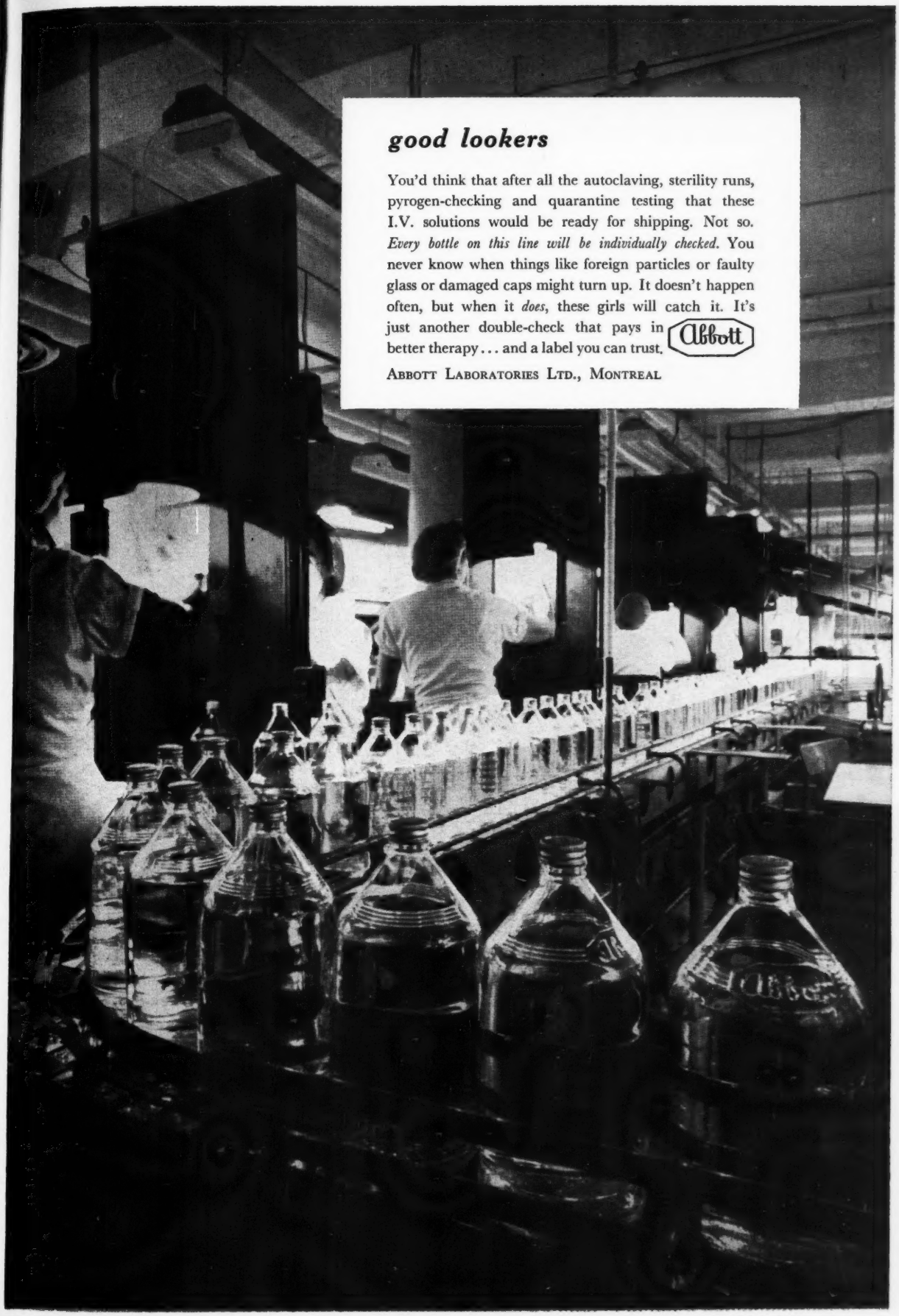
The West Kootenay Regional Hospitals Council meeting was held recently at New Denver, B.C. Hospital medical staff relations were discussed by Dr. W. S. Huckvale; and other subjects were radiological services, laboratory service, and the duties and responsibilities of trustees.

Noting that hospital incomes derive from the people who are represented by the boards of management, Dr. Huckvale felt that the triumvirate was completed by the medical staff whose purpose is to be of service to the people. He referred to the medical staff set-up in Trail, at the Trail-Tadanac Hospital, where professional service accounting is undertaken by a member of the active medical staff, who reviews the charts on each doctor's patients. Indigent patients are also assigned among members of the medical staff so that all have adequate care but the burden is distributed among all members. In addition to monthly meetings the medical staff there hold weekly ward rounds where difficult diagnostic or treatment problems are seen and discussed by the entire staff. He emphasized that the administrator, whose duty it is to carry out the policy of the board of directors, has administrative control over both lay and nursing staffs, and that medical staffs should not discuss conditions of work with nursing or lay staff members.

Dr. G. R. Callbeck of Nelson outlined the present situation regarding the development of radiological services, noting that under the proposed new federal health scheme, increased grants would be provided to the provincial governments for diagnostic and radiological services, and the services of radiologists would probably be in great demand. Dr. Lawrence Duggan spoke on the organization of a laboratory service, referring to the four main divisions: (1) tissue histology, (2) bio-chemistry, (3) bacteriology, and (4) haematology. He recommended standardization of the various methods used in this field in diverse hospitals; and advocated the adoption of a training program by the regions' hospitals to help technicians in outlying laboratories.

Mrs. G. C. Chandler, speaking on duties and responsibilities of trustees, emphasized the heavy responsibilities of hospital trustees and the wide scope of their problems. Major difficulties for them are not always financial ones, but very often problems of internal organization. It is the responsibility of trustees to formulate the policies of administration and work towards, and keep, accreditation. Trustees, she said, are guardians of the public money entrusted to them to expend for patient care. She intimated that a joint con-

(Concluded on page 78)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Here and There

World Congress Asks Acceptance of Lepers

A campaign to impress upon the general public that lepers dismissed from leprosaria are like people convalescing from any other disease and should be accepted as such by society was urged by Dr. J. G. Prieto, director of the School of Dermatology of the University of Madrid, Spain. Speaking before the International Congress for the Defence and Social Rehabilitation of the Leper, he warned that if such persons cannot gain employment because of the leprosy stigma, they become economic burdens to their fellow men.

Various physicians from Burma, India, and Equatorial Africa supported Dr. Prieto's views. Some returning lepers are not even accepted by their own families, they said, and for this reason they often choose to remain in the leprosarium.

According to Dr. Jack Penn, of Johannesburg, South Africa, plastic surgery offers great benefits to lepers. Many of those with missing features, fingers, or limbs, he feels, can be saved from becoming social outcasts with the aid of reconstructive surgery.

The Congress also heard tribute paid to the medical officers of the U.S. Public Health Service Hospital at Carville, La., for initiating sulfone treatment in leprosy. Although no panacea, the sulfones have nevertheless during the past 15 years resulted in the arrest of the infectious process in a high proportion of cases, Dr. James A. Doull, of the American Leprosy Foundation, declared.

—*Scope Weekly*

Public Health Nursing Introduced in India

There is a definite trend toward improving nursing education in India and in providing qualified people to teach; also a movement toward development of post-graduate courses of various kinds. Nurses in India, where there are approximately six doctors to every nurse, have had a difficult time trying to build up the status of the profession. Great impetus has been given health work by the opening, at the first of this year, of the Chetla Health Centre in Calcutta, first in an urban area in India. It is a combined effort of UNICEF, the government of India, and the Calcutta Corporation.

Margaret Mackenzie, a graduate of Toronto Western Hospital, is teaching in the first public health nursing course to be given in India, under the World Health Organization. It is a one-year post-graduate course, similar to that given in Canadian universities, beginning in June and ending in March.

"It is hoped to use it as an international training course for all Asia," said Miss Mackenzie, while in Canada on holiday. "Already we have students from Thailand and Indonesia and we expect to have some from Egypt."

The public health nurse is quite a new person in India, Miss Mackenzie explained. It is only within the past year that there has been registration of the public health nurse as a specially prepared person. India has the ordinary three-year basic training course with registration, but no such category as public health nurse, and no public health posts, such as are now being created within the health field.

A number of diploma and certificate courses in various public health fields are given by the All-India Institute of Hygiene and Public Health in Calcutta which has been in operation for more than 20 years. The institute is associated with the University of Calcutta, a set-up similar to the School of Hygiene at the University of Toronto.

The new urban centre is an attempt to provide a more comprehensive health program for the people. The same thing is being done at Singur Rural Health Centre, established in 1939, for the rural population.

"These demonstration centres are to provide the field work for various groups of students being trained at the institute," she said. "We hope through these centres to demonstrate the use of workers as a team."

Broadcasting at Charing Cross Hospital

Most hospitals in England have a system of radio relay whereby hospital patients may have a choice of program. At Charing Cross Hospital in London this system has been extended by the additional broadcasting on certain occasions of a "home-produced" program, devised and put over from within the hospital itself. The scheme was suggested by the House Governor to the League of Friends of Charing Cross Hospital, who were enthusiastic about the idea and undertook to arrange a program. The first broadcast was planned to be a record request program with each ward submitting its own choice. The role of disc-jockey was to include exchanges of greetings between wards and news items of personal interest to the patients. The first broadcast ran for an hour. The program was recorded on a tape recorder which the League of Friends presented to the hospital.

The program was a great success from the point of view of the content and the reproduction and it is proposed to make the broadcasts a regular fortnightly affair, to be presented between 5 and 6 p.m. in the evening. Later it is hoped to widen the scope of the programs and to record on-the-spot interviews with film, theatrical and other celebrities.—*The Hospital*

Toll of Accidents in Construction Industry

There is a three per cent chance that you will be killed before you are 65 in a work site accident if you enter the construction industry in Europe at the age of 18, an International Labour Organization report declares.

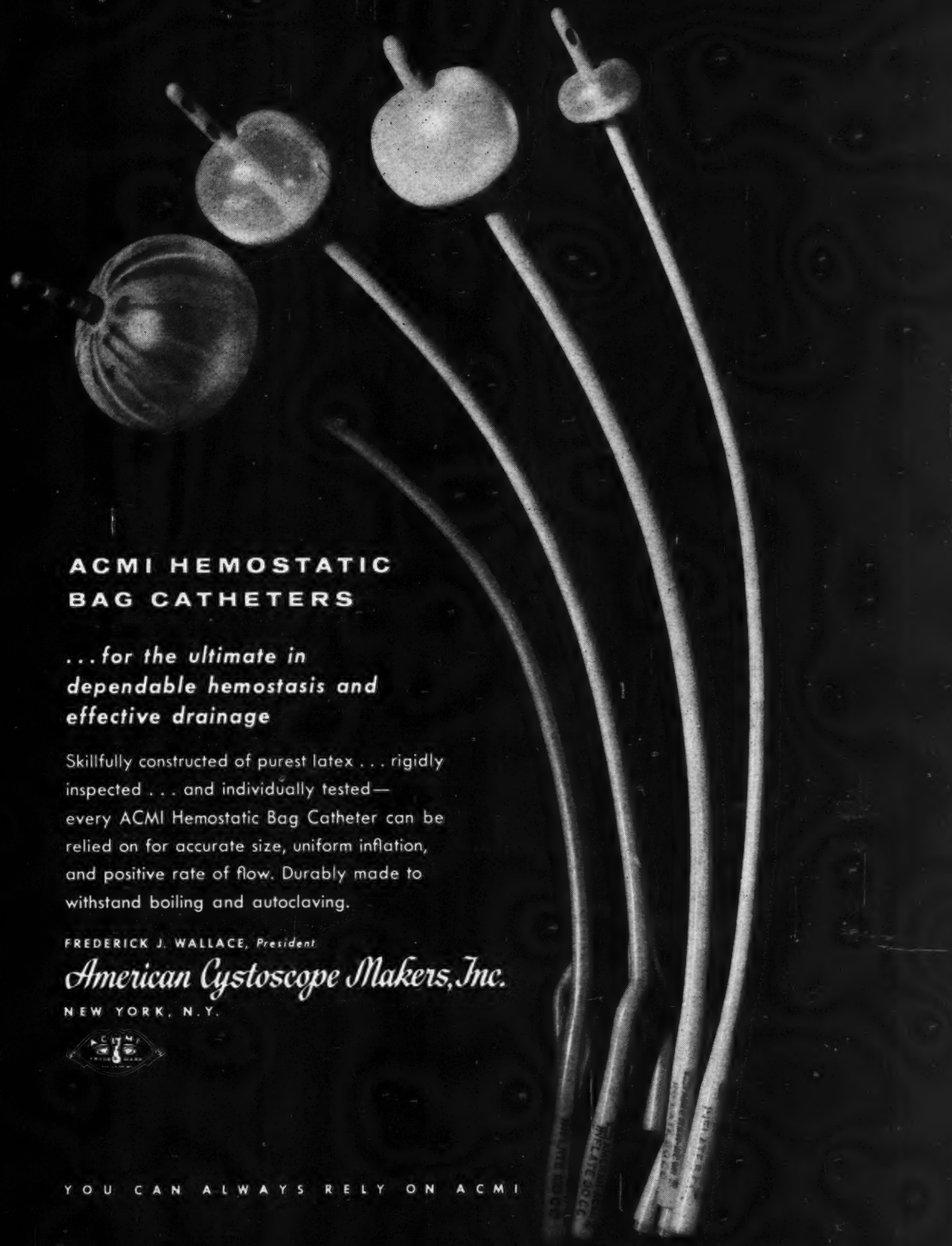
On an average, more than two workers were killed and 870 injured each day in construction site accidents in one European country. Out of every 10,000 workers entering the industry at the age of 18, no less than 300 are killed in accidents at work before reaching the age of 65, while 188 will reach that age after having lost a limb or an eye.

In addition to the toll of lives, accidents at work result in economic loss. It has been estimated that the wages lost through construction accidents around one European seaport would suffice for the building each year of 616 dwellings. — *ILO News Service.*

Epicurean Euthanasia

Thomas Parr (died 1635), lies buried beneath a worn marble slab in the floor of Poet's Corner in Westminster Abbey solely on the strength of his claim to be 152 years old.

But we have it on the authority of famed physician William Harvey that his organs were in perfect condition. An autopsy showed that death was due to "mere plethora, brought on by more luxurious living in London than he had been accustomed to in his native county, where his food was plain and homely".—*D. MacClure in "American Mercury".*



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With the Auxiliaries

Maritime Hospital Auxiliaries Hold Annual Meeting

Mrs. Gordon Leitch of Charlottetown was re-elected president of the Maritime Hospital Auxiliaries Association at the concluding session of their meeting which was held in conjunction with the annual convention of the Maritime Hospital Association, St. Andrews, N.B. It should be noted that the group has changed its name from the former title Maritime Hospital Aids Association.

During 1955, the hospital auxiliaries in the four Maritime provinces raised more than $100,000 for the purchase of supplies and equipment for Maritime hospitals, it was reported by the association treasurer. Of this amount, the New Brunswick division raised $28,070; Prince Edward Island, $13,655; Cape Breton, $14,340; and Nova Scotia, $45,075.

Dr. J. Gilbert Turner, president of the Canadian Hospital Association, was a guest speaker. He addressed the ladies on Wednesday, May 30th, on the importance of hospital aids and auxiliaries. He congratulated the members of the Maritime group on the splendid work they are doing for their hospitals and stated that, even under a national health insurance plan, the work of the auxiliaries would still remain very important. Dr. Turner urged the auxiliaries to continue their efforts in support of their hospitals.

Other officers elected were: first vice-president, Mrs. P. Connolly, Glace Bay; second vice-president, Mrs. A. M. Hunter, Halifax; third vice-president, Mrs. H. Ellison, Sussex; fourth vice-president, Mrs. Frank McCarron, Southport, P.E.I.; recording secretary, Miss Z. Garnier, North Sydney; secretary, Miss E. H. Page, Halifax; treasurer, Mrs. L. W. Brownrigg, St. Stephen; zone chairmen, for New Brunswick, Mrs. E. Ask, Sackville, for Prince Edward Island, Mrs. Clifford Sherron, Charlottetown, for Cape Breton, Miss M. McCormack, North Sydney, and for Nova Scotia, Mrs. E. H. Page, Halifax; liaison officer, Mrs. H. A. McQuarrie, Westville.

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Rocking Resuscitator

The Prince Rupert General Hospital Board has been presented by the Hospital Women's Auxiliary, Prince Rupert, B.C. with a cheque for $1,170.75 with which to buy a rocking resuscitator for the obstetrical department. This device had been given top priority by the medical staff. Originally designed for cases of asphyxia in infants, it is being increasingly used for a brief period after birth in assisting the initial respiratory efforts of infants delivered of caesarian section.

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Progress of Ottawa Auxiliaries

At the fourth annual meeting of the Women's Auxiliary of the Ottawa Civic Hospital, Ottawa, Ont., a net income of $13,714.26 — larger than the previous year's by more than $3,000 — was declared in the honorary treasurers' report. Congratulations were extended to the members of the auxiliary by Mayor Charlotte Whitton, a co-founder of the organization. Coloured slides illustrating the work of the past year were shown. A total expenditure of $16,000 to be spent on the improvement of facilities at the Civic Hospital was authorized. More than half this amount will be spent on the renovation of three public wards and two sun rooms. Other projects will include a stretcher, a fund for post-graduate work for staff nurses, the salary of a play therapist until December 31, 1956.

• • • •

$11,000 for Children's Hospital

The Women's Auxiliary of the Hospital for Sick Children, Toronto, Ont., raised approximately $11,000 during the past year, it was reported at the annual meeting. Most of the money was from the 555 shop — a venture that was started six years ago with an initial investment of $3,000. To date, daily sales of gifts and toys and articles of clothing have realized the highly creditable sum of $78,000, which has — in turn — found its way

(Concluded on page 64)

A group of hospital auxiliaries from St. Stephen, N.B. Front row: Mrs. L. W. Brownrigg, Mrs. W. A. Sinclaire, Mrs. R. Vanstone, Mrs. E. Cunningham, Mrs. James Manuel. Back row: Mrs. Fred Allen, Mrs. Justin Stewart, Miss Elizabeth Toy.

A group of hospital auxiliaries from Woodstock, N.B. Front row: Mrs. A. Bailey, Mrs. E. F. Wolverton, Mrs. J. B. Carr. Back row: Mrs. H. W. Lowney, Mrs. C. R. Dewilt, Mrs. Cecil Spence, Mrs. Douglas Winslow.

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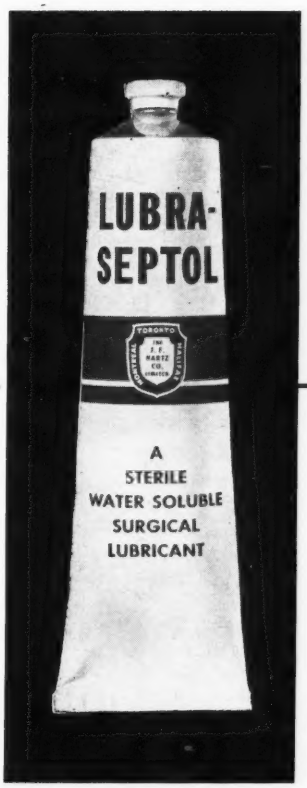

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Auxiliaries

(Concluded from page 62)

into the hospital coffers. The auxiliary now has 300 members and 54 sustaining members who have devoted more than 15,000 hours to staffing 12 services. A cheque for $7,570 was given to the hospital, of which $4,500 will be spent for research projects.

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Stupendous Achievement for New Mount Sinai

The chairman of the hospital board, at the annual meeting of the New Mount Sinai Women's Auxiliary, had every reason to address the jubilant assembled ladies in the following glowing terms: "You should all beam with a tremendous sense of pride for what you have achieved in two years . . ." Mrs. Ben Sadowski, treasurer, and Mrs. Noah Torno, president, (both re-elected to office) outlined their accomplishments. In two years the Auxiliary has raised $148,579.50, of which $50,000 was on this occasion presented to the hospital. Most of the $105,369 donated so far goes to supply free care for needy patients. Membership of the auxiliary numbers 3,367 — fees being the biggest single source of revenue; 539 volunteer workers gave 33,840 hours of service to the hospital. One big money-raising feature was the Anniversary Ball, which netted $10,849.75. The Muses were invoked by those ladies who devised "Volunteer Varieties" — a musical revue illustrating the joys and sorrows of auxiliary activities.

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Joint Hospital Auxiliaries

The tenth joint meeting of the Vanguard Union of Hospital Auxiliaries, Vanguard, Sask, was held recently for its 55 members, comprising groups from six areas. Some of the difficulties with which the smaller and more isolated auxiliaries have to contend may be gauged from the report of the Esme auxiliary in an area which had suffered from bad weather and roads during the winter — yet was able to record expenditure of over $100. The Aneroid auxiliary reported a successful drive for the Red Cross which netted $204.83; the Neville auxiliary recorded expenditure of $81.31; Pambrun auxiliary's activities included a Cancer Drive, and $127 was collected; Vanguard Auxiliary reported purchases totalling $201.24; and finally, Burton Homemakers reported donations to the hospital of a $10 fan and four binders. The meeting moved to make some joint purchases that will include a salad maker.

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Cardiograph for Wakaw

The 22 members of the Wakaw Union Hospital Auxiliary, Wakaw, Sask., made plans that will affect both the hospital and members of the public at a recent meeting. It was decided to equip the new hospital case room, to purchase a new cardiograph at a total estimated cost of $1,700, and to canvass the town for contributions to a Hospital Day lunch to be served by members of the Auxiliary.

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X-Ray Processing Unit is Major Item

At a recent meeting of the St. Elizabeth Hospital Aid, North Sydney, N.S., it was announced that the year's major project would be the purchase of a Polaroid Processing Unit, with cassettes and films. This ultra-modern machine can develop x-rays in one minute and is thus of great assistance to surgeons in the operating room itself. The aid made an initial payment of $200 towards the cost, leaving a balance that it hoped would be covered by the proceeds from the carefully planned "Florence Nightingale Tea", and subsequent activities during the year.

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A Flourishing Tradition

The Highland View Hospital Ladies Aid, Amherst, N.S., re-elected its officers to another term, learned that their 50-year-old organization was functioning smoothly, and approved disbursements of $2,462 — leaving a balance of $372. A diathermy machine was one of the chief items of expenditure. Sources of revenue are certain annual activities, such as the annual canvass, the sale at the armoury, and the Winter Fair Sacred Concert. Like many similar groups, the Aid performs invaluable work for the hospital, regularly providing essential items. A recent list includes 200 yards of sheeting and 100 yards of pillow cotton, 1 doz. men's bathrobes, 25 yards of pink eiderdown, and 50 yards of yellow embroidered towelling.

• • • •

"Un Bel Exemple Pour le Grand Public . ."

Dr. Raphael Boutin, medical director of Hôpital Notre-Dame, Montreal, P.Q., concluded his remarks to the Auxiliary of that hospital with the statement that "the auxiliary's devotion remains a fine example to the general public." The 380 members heard reports of the progress made in the many phases of the Auxiliary's activities at the 74th annual meeting. The report of the library section showed that 17 ladies devoted 789 hours to the circulation and repair of more than 5,896 books and 1,988 periodicals — in addition to foreign language publications. Expenses totalled $7,590.23 for the year. One of two medals awarded during the course of the meeting for long and devoted service went to Mlle. Marie Fitzgibbon, who had given 640 hours of work to auxiliary activities.

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Spring Fashions and Strawberry Socials

The annual meeting of the Women's Auxiliary of the Catherine Booth Hospital, Montreal, P.Q., comprised the home membership of 178, augmented on this occasion by visiting groups from Ottawa. It was reported that a total of $13,176.48 was raised from all sources, and that $11,500 had been spent on equipment for the hospital. The sources for this expenditure included such varied activities as a Sale of Work and a Spring Fashions Show ($4,583.08 raised); a Diaper Service ($1,408); a Travelling Wagon, that included the sale of brassieres ($2,160.18) to which allied sewing groups had contributed; and a Strawberry Social.

Unique Quilt Made for New Hospital

The 2,000 members of the Red Cross women's work committees in British Columbia, at the suggestion of their chairman, last year completed a "British Columbia quilt" as a gift to the new Outpost Hospital at Atlin. Fifty - four branches throughout the province rapidly designed and worked blocks, producing 63 squares, including the centre "red cross", to make the regulation size quilt which was finally quilted by the Chilliwack branch. Since this was completed a year ago, the quilt has been in such demand for showing that only recently was it sent to the Atlin Outpost Hospital. The Victoria design, with the well-known motif, "Follow the birds to Victoria", is the most colorful square of the quilt, with mountains and sea in varying shades of blue.

Chicago Alumni Fellowship Fund

Alumni of the University of Chicago Course in Hospital Administration last month contributed a second $500 to be placed in the Hospital Administration Alumni Fellowship Fund at the University of Chicago. This brings the fund to $1,000 which is invested with other university endowments. The interest from the fund is to be used for awarding an annual fellowship to deserving individuals, preference being given to persons already in the field who desire to improve themselves by attending the University of Chicago course. The officials of the University are to determine the recipient of the fellowship.

Few Canadians Critical of Hospitals

Hardworking doctors, nurses and hospital staffs can take comfort in knowing that practically half the Canadian people have no criticism to make of the way their hospitals are run. This solid body of public opinion is made up of 30 per cent who have no complaints of any kind, and 19 per cent who don't know anything about the subject, according to a report made by the Canadian Institute of Public Opinion.

Among the other half of the public, the charge that "hospitals cost too much" is laid by about one in five. That is the national average for this complaint. Regionally it runs from a high of 27 per cent in Quebec province down to a low of four per cent on the prairies and six per cent in British Columbia. These contrasts are due to the fact that there are special hospital plans, under the direction of the provincial or municipal governments, in British Columbia, Alberta and Saskatchewan.

The half dozen other criticisms which are made often enough to be represented by at least one per cent, are each made by less than one tenth of the people.

The Canadian Institute of Public Opinion instructed its interviewers to ask this question of a correct national sample, 21 years old and over:

"If you were asked to criticize the way hospitals in this area are run, what would your chief criticism be?"

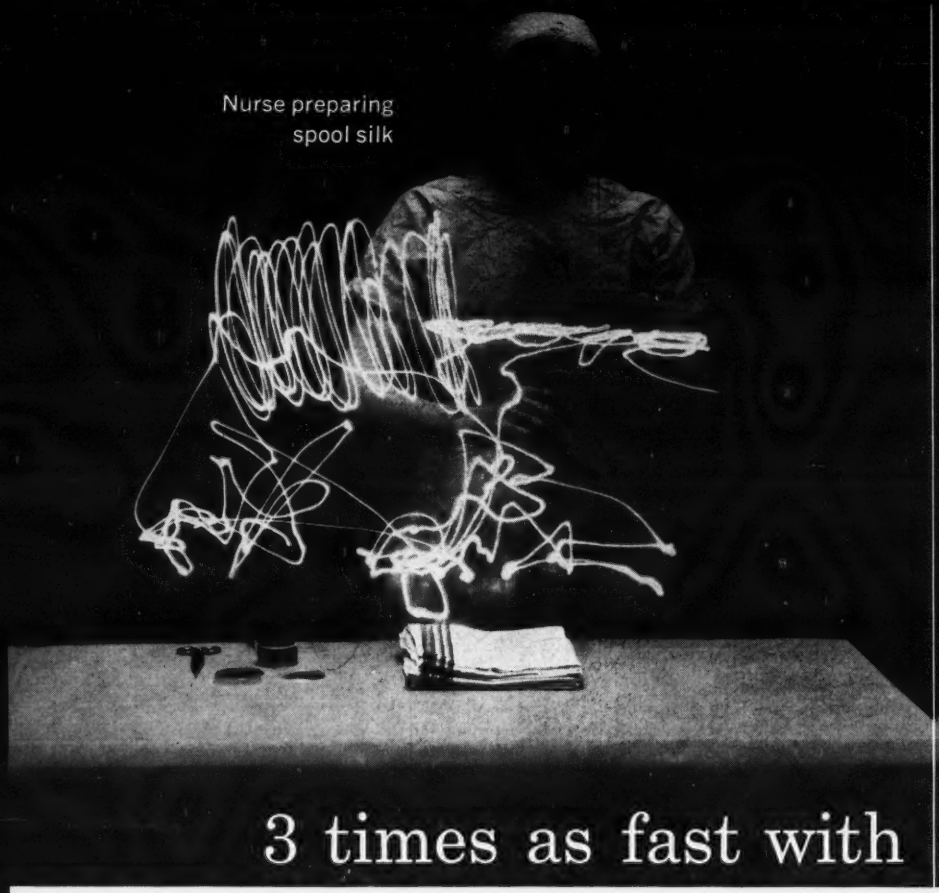
	Per Cent
No criticism	30
Don't know	19
Too expensive	18
Criticism of staff	8
Staff shortage	7
Poor administration	6
Overcrowded	5
Criticism of hospital admittance	4
Criticism of meals	4
Only cater to those with money	2
Other criticisms (Some gave more than one)	2
	105

Proud Father

Two parsons were having lunch at a farm during the progress of certain anniversary celebrations. The farmer's wife cooked a couple of chickens, saying that the family could dine on the remains after the visitors had gone. But the hungry parsons wolfed the chickens bare.

Later the farmer was conducting his guests round the farm, when an old rooster commenced to crow *ad lib.* "Seems mighty proud of himself," said one of the guests.

"No wonder," growled the farmer, "he's got two sons in the ministry."



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People

(Concluded from page 22)

Port Arthur General Board

At the first meeting of the Board of Governors this year at the General Hospital of Port Arthur, Ont., the following officers were elected: president, Mr. M. Cochran; vice-president, Mr. G. F. McDougall, Secretary-Treasurer, Miss C. L. Keehn. Miss Keehn is assistant administrator of the hospital, and is a graduate of the course in hospital organization and management sponsored by the Canadian Hospital Association.

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Awards to Canadian Scientists

Two Canadian scientists were among 16 outstanding medical teachers and researchers who have received a total of $234,853 in the 1956 American Cyanamid Company's Lederle Medical Faculty Awards. They are Dr. Kenneth F. Girard, assistant professor in the department of bacteriology and immunology at McGill University, Montreal, P.Q., and Dr. André Lemonde, assistant professor in the department of biochemistry at Laval University, Quebec, P.Q. The awards were initiated in 1954 and are intended to help assure schools and universities adequate funds to maintain promising medical men in teaching and research posts. Dr. Girard has received a three-year grant, and Dr. Lemonde a one-year grant.

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More Honours Given to Dr. Charles H. Best

Dr. Charles H. Best, head of the Banting and Best Department of Medical Research at the University of Toronto, was made an honorary citizen of Maryland at a recent ceremony in Baltimore. On his return to Toronto, Dr. Best was informed that he had been elected an honorary fellow of the Royal College of Physicians in Edinburgh. It had already been announced that Dr. Best has been elected a member of the Royal Danish Academy of Sciences and Letters. The second residential home for elderly diabetics in England is to be opened in July at Parkgate, near Chester. It will be called the "Charles H. Best Home."

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Sudbury Promotion

Following the resignation of C. E. Evans, Horace V. Snyder has been appointed administrator of the Sudbury Memorial Hospital, Sudbury, Ont. Born in London, Ont., Mr. Snyder has resided in Northern Ontario for the past 20 years. A 1955 graduate of the extension course in hospital organization and management, he has served in the hospital field for 4½ years as chief accountant at the Sudbury General and is a senior member of the American Association of Hospital Accountants.

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University of Toronto Students' Appointments

The following students in hospital administration at the University of Toronto have received their residential appointments, to study under preceptors as here listed.

Dr. G. Dudley Barnett to Dr. C. A. Wicks, administrator of the Toronto Hospital, Weston, Ont., and to Dr. A. L. Swanson, executive director of the University of Saskatchewan Hospital, Saskatoon, Sask., (divided for specialization); William B. Beatty to R. Fraser Armstrong, general superintendent of the Kingston General Hospital, Kingston, Ont.; Vernon E. Dressler to Arden E. Hardgrove, administrator of Norton Memorial Infirmary, Louisville, Kentucky; Clarence R. Horton to Dr. K. H. Gates, executive director of Jackson Memorial Hospital, Miami, Florida; Moshe Katz to Dr. Martin Cherkasky, administrator of the Montefiore Hospital, New York, N.Y.; Hugh R. McGann, appointment pending; George A. Miller to George J. Bartel, administrator of Monmouth Memorial Hospital, New York, N.Y.; Hugh Dr. Victor H. Radoux to Dr. C. MacLeod, superintendent of Sunnybrook Veterans' Hospital, Toronto, Ont.; W. Ben Stefaniuk to W. E. Leonard, general superintendent of Toronto East General and Orthopaedic Hospital, Toronto, Ont.

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The Canadian Army

Lt.-Col. Victor Hubert Radoux, CD, 42, of Prud'homme, Sask., has been named Commanding Officer of Toronto Military Hospital until such time as he will commence his residency in January 1957 as part of the hospital administration course of the University of Toronto.

Major David N. M. Hall, CD, 42, of Kingston, Ont., presently Deputy Command Medical Officer at Headquarters Western Command, Edmonton, has been promoted to the acting rank of lieutenant-colonel, and will take up his residency under Dr. C. MacLeod, Superintendent of Sunnybrook Veterans' Hospital, Toronto, to complete the hospital administration course of the University of Toronto.

• Ivy Morrell, matron of the Ponoka Municipal Hospital, Ponoka, Alta., has tendered her resignation.

• The resignation has been announced of Mrs. F. J. Kneale, director of nursing at the Welland County General Hospital, Welland, Ont.

• Many tributes were paid recently to Rev. Sister Harquail on the celebration of her golden jubilee in nursing by the staff of the Hotel-Dieu de St.-Joseph, Campbellton, N.B. She was assistant administrator of Hotel-Dieu, and still performs hospital duties.

A Memorial to Marion Lindeburgh

The death of Marion Lindeburgh at Victoria in March, 1955, brought to a close the distinguished career of a woman who is enshrined in the hearts and memories of countless nurses.

The nursing profession can record with pride her many contributions — the teaching that inspired hundreds of students, the wise and thoughtful counselling, the production of a curriculum for schools of nursing and the discharging of high offices with sincerity and purpose.

Since Miss Lindeburgh's death many nurses across Canada have expressed the hope that a fitting memorial might be created to honour this distinguished leader whose contribution to nursing has been so outstanding.

While Miss Lindeburgh's work was national in its scope, the vital part was centred at McGill University, where for 21 years she was associated with the School for Graduate Nurses, first as assistant to the director, and then as director. It is felt, therefore, that McGill University is the appropriate place at which to set up such a fund. The initiative in this matter has been taken by the Alumnae Association of the School for Graduate Nurses which, at a recent meeting in Montreal, decided to sponsor "a memorial fund for Dr. Marion Lindeburgh to take the form of a scholarship fund for the School of Graduate Nurses," and to seek contributions from nurses in every part of Canada. — *Canadian Nurse.*

United Church Makes Survey of Hospitals

A survey of the administration of United Church hospitals is being conducted by a special commission operating under the Board of Home Missions of the United Church of Canada. The commission is seeking information from federal, provincial, and municipal authorities regarding government policies toward hospitals. Its report will come before the general council of the church, which meets at Windsor in September. Chairman of the commission of 18 persons is Dr. J. C. Pincock of Winnipeg.

The church operates 13 hospitals, seven under the home missions board and six under the Women's Missionary Society.

Social Sciences

(Continued from page 55)

the investigator in hospital performance is that the formal blue-print of expected role-performance is so neatly and so completely drawn up, and yet so frequently the actual performance turns out to comply with another set of informal norms and rules, on the level of the folkways and mores, and the professional ethical codes, rather than the prescribed procedures. This relationship of the formal to the informal patterns of behaviour turns out to be a critical variable, indeed, in understanding repetitive behaviour traits in the sub-units or categories of personnel.

The Concept of Community

The concept of the community is found in both academic and popular usage. However, there is vagueness and confusion with respect to the practical use of the term or concept. How does one identify a "community" in the first place? What are its distinguishing characteristics? What constitutes the "hard core" of a community and where lie the perimeters? In a given area, is the core; and are the boundaries the same for different agencies with different purposes? What criteria may be used simply for the identification of communities? Real ones, like natural geographic phenomena, or political, or purely functional and operational for a given agency and purpose?

Too many populations of different kinds are called communities indiscriminately! So long as a ward of a particular hospital, or three or four households on a dead-end street, or a block in a city, or the opposite sides of two blocks separated by a street, or a suburb, or a borough of a city, or the residence-radius of the patients of a hospital, school or factory may all be called a "community", there is going to remain much confusion in the use of the concept. We may even hear the phrase "community of nations". What is implied?

Until we mean the same thing in substance, when we use the term, we may think and talk past each other. Even when we decide or agree upon what we shall mean when we say community there is serious work to be done. What are the common denominators in the concept of communities? Is there always a geographic or ecological base? A common binding element or interest? A clustering of institutions? An interlocking structure? Centres of power and an identifiable leadership?

Until we know what we mean and mean what we say, in our use of the term, it cannot lend itself to much understanding. So, some agreement on the identification of communities comes first. Next, some identification and comprehension of the fundamental variables in all communities is essential to any comparative analysis of communities as such. Knowledge of the significant dimensions of communities in general would appear to be a "must" for understanding the generic term. And for generalization about communities to fit more like a glove than a mitten, a classification of communities and generalizations limited to particular categories of communities becomes a practical, and perhaps logical, next step. Can we classify communities: What classifications do we need most?

When we can think precisely, systematically, and categorically about communities and consider how these concepts may tie in and correlate with our classifiable categories of hospitals defined as institutions, then we may begin to conceptualize our knowledge around particular types of hospitals in specific kinds of communities; and thus generalize more accurately and comprehend more deeply. To take this comparative and correlative analysis of the community-institution a step further, let us consider the subdivisions and stratified social segments of the community as they correlate with corresponding segments in the hospital. To what degree does one find, or expect to find, segmentations within the hospital that replicate those existing within the community, and how do these reinforce each other? Do, for example, the distinctions made between ward patients and private patients, so characteristic of general hospitals, actually have their roots in the socio-economic stratification in the surrounding community? Are qualities and quantities of patient care correlated somewhat along these strata planes? How are definitions of health needs and patient care correlated along the same lines?

If it is true that physicians generally are drawn from middle and upper classes in communities and nurses and aides from middle and lower classes, how does this influence their relationships with each other and with the different categories of patients, such as ward and private? What are the implications of community stratifications and segmentations for the kinds and volume of ailments treated in the hospital? How are the possibilities of preventive or rehabilitative medicine conditioned by these community factors?

Are there grounds for assuming that what the hospital may accomplish as an institution and how it may do this is substantially determined by the existing community components? To use the figure of the glove and the mitten in a somewhat different sense, what categories of hospitals fit into what types of community like hands in gloves and what others like hands in mittens? And how may such knowledge yield understanding of hospitals?

There is for the administrator a further very pertinent concern for knowledge of the community, especially if the relationship of his hospital is a hand-glove affair and he must rely upon this relationship for endorsement, support, and co-operation in policy and program. Then he will need as systematic a procedure in community analysis as in hospital analysis. He will be concerned about the level of health needs that may be demanded or receive endorsement in the various segments of the community, as well as the resources for underwriting these needs.

It will be equally important for him to learn where are and how to reach the divisions making social units in the community, the structures and lines along which the economic and social power of the community moves, and the leadership personnel. He stands in need of any key concepts and standardized checks and procedures for this kind of very practical community analysis. To be sure, he may learn by rote and play by ear, with plenty of trial *and* error, but that is a poor compromise for systematic procedure, and a still poorer substitute in making his staff community-wise. A premium is placed here on any key concepts that may unlock community resources.

An area of community dynamics of particular importance to the administrator is the professional leadership personnel of the community who, generally like himself, have been imported from other communities far and wide. Their orientation, motivation, and career dynamics in the various agencies that they represent are based outside and often beyond the immediate community. In short, they may and often do view their present community project as just one more rung in a career ladder that leads up and over into another and still another community. Therefore, although they hold key and strong positions as representatives of the community, they are moved to act under a somewhat different set of motivations. For example, it may better meet their needs and interests to co-operate in, support, and promote some popular and short-term project, rather than a more basic long-term program that might hold back their progress on the career ladder. We need studies that may provide us with glove-fitting concepts to understand and cope with this kind of community dynamics.

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Staphylococcus

(Concluded from page 34)

that produced neutralizing enzymes against the drug. The wide use of penicillin brought forth a selective increase and spread of these strains; and they are today in the majority. The studies of this situation revealed furthermore that these penicillin-resistant strains also were more virulent and that they became especially so when they were treated with penicillin. This can be explained by the observation that the drug will cause some damage to the bacteria, but it will not eliminate them unless administered in very high doses and under consideration of the special location of the invaders behind walls of demarcation and within zones of bad or missing vascularization.

Those staphylococci which survive inadequate treatment with penicillin will do so with a rapid increase of reproduction and a higher output of enzymes or toxins. If they are spread from their first victim to others, this increased virulence will prevail for some time even on a bedsheet or in the nose of a healthy carrier and will, if a suitable new victim is found, show faster spread, produce larger damage to the tissues, and in general develop greater resistance to our drugs. This build-up of virulence now goes on steadily in an epidemic and we must recognize the notorious strain 81 as one of those strains that we can relate to the serious conditions we encounter today. Apparently these strains also find means to evade the effect of the more potent broad-spectrum antibiotics, as seems evident from their increased rate of failures. We have also tested strain 81 against antiseptic lotions and detergents, and it seems from a few tests that it withstands them for a longer time than the classical test-strains, like the Oxford-strain, have done when these antiseptics were brought onto the market.

Discipline

I want now to relate a very important experiment Dr. Gould, a British bacteriologist, made in the cross infection of a medium-sized British hospital last year.

As many cases of boils and other conditions had been contracted in the hospital, he proposed to have everybody on the staff anoint their nostrils with achromycin ointment for ten days, daily, before they went on duty, He also had antiseptic hand lotions made available for frequent use during duty. Everybody was strictly bound to follow his advice and apparently did. Within a short time new cases of staphylococcal conditions failed to appear and from then on the cross infection could be controlled.

It shows how important the interruption of the carrier chain is and that we *can* control these cross infections by reasonable measures and strict discipline. The latter means is the most important, however.

Recently an experienced physician told me he felt that the most important thing I offered was advice concerning general cleanliness. Well, there I am again. Cleanliness in hospitals is something more than in non-medical institutions. It involves a thorough antiseptic technique, as well as a thorough understanding of infectious happenings. We need a training program here as much as strict antiseptic techniques — because the number of untrained persons working on our wards equals that of professional staff. But, above all, we need the understanding of the hospital authorities. These people have many problems on their minds and an important one is that of public relations. Understanding of the factors involved will help to arrive at the compromise that is necessary to control a cross infection

To be clear — in such emergencies everything else takes second place; the hospital must not be overcrowded (that goes for the physicians); the staff may have to put in overtime to accomplish antiseptic measures (that goes for all staff). Expenses, to make changes in arrangement of wards, must not be avoided (that goes for the business officers).

A strict policy must be laid down, binding all members of the staff to follow one reasonable policy of prevention; and the public must be educated not to spoil the efforts of the hospital staff with regard to cleanliness and isolation measures.

Finally, instructions must be provided that include all members of the staff. (That goes for our notorious hesitancy to arrange for instruction meetings.)

In short, if I say compromise, I mean that of our present tendencies to make life agreeable, by saving trouble in public relations, with the hard fact that bacteria are relentless fighters and will take advantage if we are lax. I hope I have not hurt the feelings of anybody; but I have seen a number of cross infections and am convinced that there is no other way to get rid of them than to get tough with ourselves, at least for a short while. Only then will a nice and rather strikingly simple measure, like that of Dr. Gould, have success. ●

Reducing Retrolental Fibroplasia

Infant blindness caused by retrolental fibroplasia dropped 83 per cent in the past year in New York State, since hospitals adopted procedures limiting oxygen concentrations given to premature babies.

This definitely shows that retrolental fibroplasia can be controlled, according to a report by Dr. Alfred Yankquer, director of the Bureau of Maternal and Child Health for the State Department of Health; Dr. Harold Jacobziner, assistant commissioner for Maternal and Child Health Services of New York City; and David M. Schneider, PhD., director of Research and Statistics, State Department of Social Welfare.

The team pointed out that high concentrations of oxygen administered to premature infants appear to affect blood vessels in the retina and to cause scarring. After a time, the retina, as a result of the scarring, shrinks and eventually is destroyed.

They reported that the effects of curtailing oxygen in premature baby care can be observed as a result of the state requirement that all cases of blindness be reported to the state Commission for the Blind. They pointed out that statistics tell the "striking story" of the sharp rise and even sharper decline of this disease. Beginning in 1946, the year reporting was made mandatory, the number of babies classified as blind during the calendar year of their birth increased steadily each year, reaching a peak of 52 in 1953. In 1955 there were only three reported cases.

"The number of infants classified as blind during the calendar year following their birth was 92 in 1953 and then declined to 27 in 1955," the above physicians reported in an article published in the *New York State Journal of Medicine*. The higher numbers in this second instance are due to the fact that all experience indicates the heaviest "reporting year" as the calendar year after an infant's birth year, they stated. They further explained that the number of babies born in 1955 but not classified as blind until 1956 cannot be reported until the end of the current year.—*Scope Weekly*.

Statistics Show

The old gentleman was buying a pair of shoes. He said he didn't think the leather was very good. The salesman said, "The leather in those shoes will last longer than you do." The elderly gentleman, who was 98, said, "Young man, that's where you're wrong. Statistics show that fewer people die after 98 years of age than at any other age up to that time."

Time and Motion

(Concluded from page 35)

be done periodically as a check. Our average proved to be 500 lbs. per day. Information obtained from an article entitled *Planning the Hospital Laundry*[1] told us that hospital laundries should process between 125 and 175 pounds dry weight per employee per day, or an average of 150 lbs.

We did not know whether this applied to our hospital as it was only an average, and other factors, such as the number of small and large pieces, have a bearing on the matter. However it was a starting point and the weight that we were processing indicated that four employees might be able to handle the work load, whereas we had seven. In actual fact, the time and motion study disproved the indication in our case. It did call for a relocation of our presses to save unnecessary handling and corrected a number of errors in the employees' methods. Certain conditions were brought out that could not be corrected short of rebuilding the entire plant. These, however, will be major issues in a forthcoming building program. Besides proving that the laundry was overstaffed and could be operated efficiently with five employees, the time and motion study also proved that we could meet industrial laundry wage rates and thereby obtain a higher standard of employee. It proved, moreover, that we could do so while saving the hospital $1,200 per annum.

The next group studied was the cleaning staff and here again we were able to reduce staff from eight to five, increase wage rates to a level offered by other employers in the community, and save over $2,000 annually. Similar studies in our maintenance crew have saved over $5,000 a year. None of this could have been accomplished without a time study.

These examples of what time and motion study have accomplished for our hospital and for the taxpayers that support it would seem to indicate that the hospital was very poorly organized before the studies were carried out. However it is my contention that this was not the case; but rather that it was as well organized as any hospital in which time and motion methods are not employed.

Although we have picked out only three groups to date, we hope eventually to do all departments including all branches of housekeeping, food service, and nursing. For hospitals with an outpatient department, Dr. Charles U. Letourneau gives yet another use of the time and motion study — the evaluation of the outpatient department for better care[2].

Who Should Do The Job?

We come now to the question: "Who should do a time study?" Is it necessary to have it done by a firm of industrial engineers or can the administrator conduct it? This is debatable. Everyone has heard of efficiency experts who, by their methods, make enemies, in the course of such a study. Because of this their results are not always accurate. There is, also, the point that no one should know the hospital as well as the administrator and, in my opinion, he is the best man for the job — providing he has the confidence of his board. Some boards are not astute enough to realize this and, immediately the subject is broached, they call in outside experts. In all probability, they would be doing their hospital a favour if they placed the administrator in charge of the job. If the hospital is so large and the job so involved that the administrator feels he needs help or guidance, then he should persuade his board to let him confer with a reputable firm of time and motion study experts. He might even wish to have them place one or two men who have been trained in the art of measuring time and motion in his hospital.

Numerous books are available on the subject and every hospital administrator should acquire not a superficial knowledge of the science but should study it. He should read one or more books and keep them on his library shelf for reference. Books used in our hospital are *Motion and Time Study* by Ralph M. Barnes, published by John Wiley and Sons, and *Primer of Time Study* by F. W. Shumard, published by McGraw Hill. Lillian Gilbreth, personnel consultant, of *Cheaper by the Dozen* fame, in an article entitled *Time and Motion Study*[3] recommends the works of David Porter, Marvin Mundel, and Allan Mogensen, as well as *Factory Management and Maintenance*, edited by L. C. Morrow.

It is not possible here to dwell on the technical aspects of a time and motion study. Nor is it wise to give specific times for various motions. Due to layout, distances, and the location of various departments in relation to others, times for specific elements of a task in your hospital would be much different from ours. It will suffice if I mention here that there is more than one method of timing motions. They may be timed separately or severally, depending on the complexity of the task. An assembly line study would time each separate motion. The study in a hospital is much simpler in that, in most cases, several motions may be timed together.

All the required technical data may be obtained from the text books and articles previously mentioned; and every administrator owes it to himself and his hospital to become thoroughly familiar with the subject.

To Accept or Reject the Challenge

It is granted that the very nature of institutional operation, and especially of nursing and related tasks, does not lend itself as readily as does the assembly line to time and motion studies. Nevertheless every task has its component parts and the principles of time and motion study apply just as much here as in a manufacturing operation. It is the very basis of establishing proper standards of performance and staff scheduling. And of course the breakdown of a surgical or nursing procedure is basically the same as for any procedure, i.e., "Make ready", "Do" and "Put away".

Although it may be hard to believe that your hospital is not as productive or efficient as it could be, it is a certainty that, without a time study, you will not know how much better it could be, either from the point of view of service to the patient or that of cost to the payer. It is the most important subject facing hospitals today because only by its use can they justify both their actions and their costs. If you accept the challenge I cannot say that your financial position or patient care will be improved but at least you will have justified them and I am sure you will agree that the saving to our hospital is a strong indication that time and motion studies are applicable to hospitals and worth a trial.

References

1. Modern Hospital, Nov., Dec., 1949.

2. Hospitals, Oct., 1951, "ATS for better OP care."

3. Modern Hospital, September, 1954.

"I love reading but . . ."

Many people have been heard to say: "I love reading, but never have a minute for it." That is a matter of choice, governed by a sense of values. We find time for the things most vital to us.

Even half an hour of daily reading will bring a rich reward. Looking backward, we shall see that those half hours, retrieved perhaps in fragments from the grasp of daily routine, count for more than we ever thought possible. —*The Royal Bank of Canada Letter.*

Social Sciences

(Concluded from page 72)

One more conceptual point about community dynamics should be raised. It is the question as to whether there are any general steps and natural order or sequence in the taking of these steps in the process of community-project promotion. Another way to place the question is to ask, "Can any principles and patterns be formulated concerning the nature and order of community processes in directed project promotion?" Can these principles and patterns be generalized reliably within particular classifiable categories of communities? This is a large experimental field, mostly on a trial-and-error basis.

Shaping Health Aims

A basic concept for understanding of human behaviour, group-wise or otherwise, would seem to be knowledge of the purpose for which it is performed. In purest psychological terms we speak of this mainspring of individual as "stimulus", which is generally broken down into what is called "drive" and "cue". The whole cycle in simplest terms is drive, cue, response, and resultant effect—either reward with reinforcement or punishment with extinction. Drive is to want something; cue is to notice something to do; response is to do it; and resultant effect is to get something as a consequence.

In organized group context (to be more specific, in institutional settings), the drive to want something is described as the group-derived purposes, the goals, aims or objectives toward which the institution strives—the charter norm, in short.

This kind of approach to the problem of hospital practice presents a challenge to our medical administrators perhaps above all others. First, there is the challenge of medical statesmanship in what constitutes a difficult field of complex and conflicting forces. In addition to this urgent present need in the health field, and to guide it in long-term perspective, is the need for collaborative research between medicine and the social sciences toward a more effective application of the knowledge of medicine to the needs of man. In terms of relative potentialities, the field is fallow, the workers are few.

Kootenay

(Concluded from page 58)

sultative committee of trustees, medical staff, and the administrator was a good way of maintaining good relations between the board and the medical staff. Following an address by J. W. Clarke of Slocan Community Hospital, New Denver, B.C., on the subject of chronic care, this resolution was adopted:

"Whereas the existing facilities for chronic patients in B.C are inadequate be it resolved that the government agencies involved should be provided with the proper legislation to effect the provision of adequate chronic care immediately, and further be it resolved, that provision be made to change existing legislation in order that provision may be made for the payment of chronic patient expense incurred in acute hospitals, until accommodation can be found in chronic institutions."

Those attending the meeting visited the School for Doukhobour Children and the Home for Aged Japanese Men.

Elected by acclamation were the following officers for 1956-57:

Chairman — H. L. Christian, Rossland; vice-chairman — J. H. Hargraves, Trail; secretary — Vera B. Eidt; regional representative to British Columbia Hospitals Association — Vera Eidt. ●

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Twenty Years Ago

("The Canadian Hospital", July 1936)

Now-a-days nearly every medical graduate, who intends to practice medicine, takes one or more years' internship. Very few indeed of the final year men now go directly into practice without having supplemented the academic training by a period of internship. In days gone by only the fortunate few were able to avail themselves of this training; but we are now informed that many times the entire class will have obtained appointments, either on hospital wards or in their laboratories, and we are informed also that, in some of the provinces, practically all applications for licensure received are from those who have had one or two years of practical hospital work at least.

Do each of your trustees receive a copy of *The Canadian Hospital*? If not, get them to subscribe, for they will learn more about your problems and thereby help you.

In view of the desire of hospital authorities throughout Canada to see established a uniform accounting system in all public hospitals, it would seem absolutely necessary for hospitals to keep complete records of the number of patients cared for in private, semi-private and public wards. Unfortunately, the percentage of public hospitals that are able to give accurate information under these headings is extremely small and the figures submitted do not lend themselves, at present, to close analysis.

What do you recommend as the ideal flooring for a hospital? — We do not think that any flooring has yet been designed that will meet all the requirements of good hospital service, namely, low initial cost, durability, minimum upkeep, sound absorbing properties, and sanitation. Terrazzo floors seem to be in greatest use because, if installed with the building, their initial cost is not prohibitive and the upkeep is very low; but even if laid in section they have a tendency to crack. They are noise reflecting and cause fatigue among nurses and other staff. We believe that if cost is not a final factor, the so-called battleship linoleum or rubber tile is the all-round choice. Floors of this type have extremely long life providing they are laid properly in the original instance.

Signal honour was paid this spring to Miss Annie L. Laird, Professor of Household Science, University of Toronto, by the unveiling and presentation of her portrait to the University.

Quite a number of leading Toronto physicians devote a part of their hard earned leisure to the pursuit of Art, with extremely pleasing results. Visitors to the doctors' lounge of the Toronto Western Hospital will have an opportunity of viewing several beautiful oil paintings by well known medical men. Three of these were painted by members of their medical staff — a view of Lake O'Hara by Dr. J. M. McKinley, eye, ear, nose and throat specialist, and an autumn scene by Dr. F. C. Trebilcock, chief of their department of ophthalmology, and a winter study by Dr. W. H. Beecher Locke, urologist. Dr. Harvey Agnew contributed a lovely painting, taking as his subject a totem pole scene in an indian village near Wrangell on the Pacific Coast, reminiscent of his visit to Alaska two years ago. Donations of paintings by several other members of the medical staff are anticipated.

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What To Do About Long-Term Patients

At this time it is appropriate to consider chronic illness for at least two reasons: first, because of the growing need for adequate care of this type of patient, and second, because the provincial government has recently indicated that something will shortly be done about the problem of chronic care. Of particular concern are those who, through various ailments due largely to senile age, require treatment and supervision; this type is, of course, not new to us. Previous to the introduction of the British Columbia Hospital Insurance Service our hospitals faced the problem of caring for a number of such patients, particularly through the winter months and usually with no compensation other than the meagre amount received from the municipality concerned; charitable donations played a large part in keeping hospitals solvent.

Many of us can remember a time when chronic illness was not considered a matter of great importance; family life was more closely co-ordinated. It was customary for the eldest son to assume responsibility for the care of aging parents, and no assistance outside the family circle was deemed necessary or desirable. Many of the prevalent difficulties associated with long-term patients today scarcely existed a century ago. Our speeded-up living habits are no doubt largely responsible for our predicament.

Tremendous progress in medical science has been made in recent years and as a result more people are living far beyond normal years of usefulness. This situation will possibly become greatly exaggerated. We are told, on expert medical authority, that the coming century will see the average life expectancy increased to 115 years, and a young man who dies before ninety may be suspected of having bad social habits. Perhaps it is just as well that none of us will be around at this period of our so-called civilization.

Our problem today is probably partially due also to the fact that we were engaged in two major wars only a generation apart, and the present population, as a result, is badly off balance in that we have too few young people and too many old. This condition is not liable to change in the foreseeable future. What then should we do toward a reasonable solution of the present situation?

So far as we now know only one plan has been discussed—that of adding special wards or buildings to extend our present hospitals. This, in our opinion, is not logical from an economical point of view, nor desirable for the type of care we are considering.

Hospital beds costing from $5,000 to $10,000 are surely beyond reason. If such a plan were adopted we would be doing too much for too few, and too many would necessarily be placed on an ever-growing waiting list.

We are living in a particularly dangerous age and should be concerned with dispersing our population as much as possible; hospitals in large centres would become a matter of grave concern should disaster strike, and any attempt to clear them would no doubt result in heavy loss of life. Why, then, take chances that can and should be avoided? Even our local home for long-term patient care (the Home for Aged Japanese Men at New Denver, B.C.)

(Concluded on page 84)

From an address by J. W. Clarke, New Denver, B.C. at the West Kootenay Regional Hospital Council Meeting.

St. Joseph's Hospital, Subdury, Ont.
St. Elizabeth School of Nursing
P. J. O'Gorman, Architect

another fine hospital selects Clerk windows

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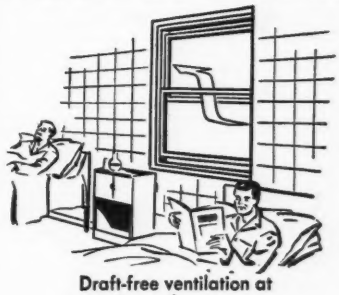

Draft-free ventilation at meeting rail

When planning new buildings or expanding present facilities, exacting hospitals find CLERK windows the only possible selection. Reversible sashes, originated by CLERK, permit easy, safe and economical cleaning from inside. CLERK windows are equipped with Pressure Seal double glazing and exclusive high wool pile weatherstripping. These assure satisfactory operation at all temperatures and reduce maintenance and heating costs.

CLERK windows are precision made from quality materials — to perform smoothly and efficiently for the life of the building. No other window, foreign or domestic, can match them. *Clerk Windows Limited, 1499 Bishop Street, Montreal 25, Canada.*

CLERK Windows equal or exceed quality window specifications as to quality of materials, fabrication, strength of sections and minimum air infiltration.

CLERK WINDOWS

CLERK WINDOWS ARE AVAILABLE IN ALUMINUM, WOOD AND ALUMINUM-COVERED WOOD

Coming Conventions

Aug. 12—Canadian Society of Hospital Pharmacists, Ottawa, Ont.

Aug. 28-29—Maritime Conference of the Catholic Hospital Association of Canada, Notre Dame D'Acadie Convent, Moncton, N.B.

Aug. 29-Sept. 1—Canadian Society of Radiological Technicians, Empress Hotel, Victoria, B.C.

Sept. 12-13—Catholic Hospital Conference of Alberta.

Sept. 15-19—American College of Hospital Administrators Annual Meeting, Palmer House, Chicago.

Sept. 17-20—American Hospital Association Convention, Chicago, Ill.

Sept. 17-20—American Association of Hospital Consultants, Palmer House, Chicago, Ill.

Oct. 1-5—International Congress on Medical Records, Shoreham Hotel, Washington, D.C.

Oct. 10-12—Convention, Canadian Association of Medical Record Librarians, Vancouver, B.C.

Oct. 16-18—Associated Hospitals of Alberta, Macdonald Hotel, Edmonton.

Oct. 22-23—Catholic Hospital Conference of Saskatchewan, Saskatoon.

Oct. 22-24—Ontario Hospital Association Convention, Royal York Hotel, Toronto, Ont.

Oct. 24-26—Saskatchewan Hospital Association Convention, Bessborough Hotel, Saskatoon, Sask.

Oct. 25-26—Ontario Conference of the Catholic Hospital Association, St. Joseph's Hospital, Toronto, Ont.

Oct. 27-29—Canadian Association of Occupational Therapy, Montreal.

Oct. 30-Nov. 1—Manitoba Hospital and Nursing Conference, Winnipeg, Man.

Nov. 1-2—A. H. A. Institute on Operating Problems of Small Hospitals, Winnipeg, Man.

(Concluded from page 82)

is far from adequate, but it has during the past ten years filled a void and been the means of keeping a limited number of our aged oriental friends comfortable and comparatively contented.

Should we encourage the establishment of large long-term hospitals situated in bigger centres with extreme cost per patient, or should we promote the establishment of smaller local units where the inmates would be close to home and friends at a minimum expenditure. In either case the goal should be to establish for those in need of chronic care and lacking funds a measure of comfort, insofar as available resources will allow. ●

Grants to Aid Research on Heart Disease

The Life Insurance Medical Research Fund announced recently that it has awarded $960,340 in grants and fellowships to aid research on heart disease this year. The new awards bring to $8,161,170 the total of the Fund's contributions to this vital work since its organization in 1945.

This year's allocation includes $849,640 as grants-in-aid for 58 heart research programs and $110,700 to support 22 fellowships for young men and women in training as research workers. Studies under these awards will be conducted in 49 institutions in various parts of the United States, in Canada, England, and the Netherlands.

Canadian research grants go to:

University of British Columbia Faculty of Medicine, Vancouver, B.C.: for research by Dr. P. Constantinides on the effects of certain anti-arteriosclerotic agents on reticulo-endothelial tissues, $7,260; and for research by Dr. Edwin E. Daniel on the role of electrolyte changes in smooth muscle in hypertension, $11,000.

University of British Columbia, British Columbia Research Council, Vancouver, B.C., for research by Dr. H. G. Khorana on synthesis and properties of nucleotide coenzymes, $22,000.

University of Western Ontario Faculty of Medicine, London, Ontario, for research by Dr. Robert C. Buck on the permeability of arterial and venous linings to large molecules, $10,560.

Canadians receiving fellowships are:

Cyril Max Kay, of Calgary, Alberta, for study with Dr. Kenneth Bailey at Cambridge University, Cambridge, England.

R. Foster Scott, M.D., of Edmonton, Alberta, for study with Dr. W. Stanley Hartroft at Washington University School of Medicine, St. Louis, Mo.

Leonard Warren, M.D., of Toronto, Ont., for study with Dr. John M. Buchanan at Massachusetts Institute of Technology, Cambridge, Mass.

George F. Wilgram, M.D., of Toronto, Ont., for study with Prof. Charles H. Best at the University of Toronto, Charles H. Best Institute, Toronto, Ontario.

Samuel I. Yamada, Ph.D., of Toronto, Ont., for study with Prof. U. S. von Euler at Karolinska Institute, Stockholm, Sweden.

In announcing the 1956 grants and fellowships, Dr. Francis R. Dieuaide, scientific director of the Life Insurance Medical Research Fund, said they would enable scientists to study many of the problems that must be solved to make possible the control of hardening of the arteries and high blood pressure. Prominent among the subjects of research are causes of coronary artery occlusion. Improved methods of treatment for present sufferers are also being searched for.

Diseases of the heart and arteries are now by long odds the chief cause of death. Their fatal impact falls on those in the prime of life, as well as on the aged. While much remains to be done to enable us to prevent these deadly maladies, the outlook today is one of confidence in ultimate success, whereas ten years ago an attitude of despair prevailed.

The Life Insurance Medical Research Fund is supported by contributions from 150 large and small life insurance companies of Canada and the United States. Its resources are devoted entirely to the fight to gain control of heart disease.

An ideal husband is one who treats his wife like a new car.

Does your staff have the right I.V. solution available for each patient's needs?

Specific fluid and electrolyte losses are now easily determined with modern tests like the flame photometer for potassium and sodium levels. As more is learned about fluid/electrolyte balance, a greater range of I.V. solutions is needed at the hospitals.

Cutter meets these needs with a complete line of special and standard electrolyte and nutrient solutions. Below are a few typical cases of how Cutter meets specific needs of each patient.†

† The complete line of Cutter Special and Standard Electrolyte Solutions and Additives, arranged in a convenient mEq table, is available upon request.

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270 Main Street So., Weston, Ontario

Abstracted Case Histories

Case 1 – Male, 24 years. Condition: Herniotomy. Therapy: Prevent acidosis and restore electrolyte balance with postoperative use of Cutter Poylsal®.

Case 2 – Female, 53 years. Condition: Resection of sigmoid carcinoma with ileostomy. Therapy: Correct acidosis, prevent hypopotassemia and maintain daily body requirements of electrolytes, carbohydrates and water with Cutter Polysal-M.

Case 3 – Male, 42 years. Condition: Alkalosis following pyloric gastric obstruction and gastric drainage. Therapy: Combat alkalosis with Cutter Invert Sugar 10% in Electrolyte Solution No. 3 (Cooke and Crowley's Gastric Solution).

Case 4 – Female, 27 years. Condition: Diabetic acidosis. Therapy: Alkalyze and stabilize with Cutter Polysal and then follow with Cutter Invert Sugar 10% in Electrolyte Solution No. 2 (Butler's Formula).

Case 5 – Male, 54 years. Diagnosis: Postoperative small bowel obstruction with drainage by Miller-Abbot tube. Therapy: Replacement of daily fluid and electrolyte losses with Cutter Invert Sugar 10% in Electrolyte Solution No. 1.

Case 6 – Female, 31 years. Condition: Severe diabetic coma. Therapy: Initial treatment with Cutter M/6 Sodium Lactate Solution.

Case 7 – Male, 42 years. Diagnosis: Gastric carcinoma. Therapy: Combat protein deficiency with Cutter C.P.H.* (5% Protein Hydrolysate in 5% Dextrose Solution).

Case 8 – Female, 1 year, 2 months. Diagnosis: Irritative diarrhea with hypopotassemia. Therapy: Restore fluid and electrolyte balance with Cutter KNL® (Darrow's Solution).

*TM

Staff Wanted

Eastern Ontario Hospital—150 beds—general acute, 100 bed addition planned, requires: Assistant Director Nursing Service, Assistant Director Nursing Education, Obstertcila Supervisor, Central Supply Room Supervisor, Registered Medical Record Librarian, Registered Laboratory Technician. Please state educational background, experience and approximate salary required in first letter. All communications will be treated confidentially. Please reply to Box No. 728B, The Canadian Hospital, 57 Bloor Street W., Toronto.

Staff Nurses Grade 1 Wanted

By B.C. Civil Service for Provincial Mental Hospital Essondale, for permanent positions and summer relief work. Salary: $239. rising to $271. per month. Must be a registered nurse currently registered in B.C. or eligible for registration in the Province. Preferably some experience in general nursing. Applicants must be British Subjects. For further information and application forms apply Personnel Officer, Civil Service Commission, Essondale, B.C. Phone LA 1-1911.

Assistant Superintendent, Medical, Required

University of Alberta Hospital, Edmonton, Alberta, Canada requires Assistant Superintendent, Medical. Starting salary $7,800 per annum. Annual increments of $500 to $9,800. Give full particulars, name, references and enclose photograph first etter, to A. C. McGugan, M.D., Superintendent, University of Alberta Hospital, Edmonton, Alberta, Canada.

Administrator Wanted

For 100-bed general hospital. Applications will be received until July 30th. Address applications, including full particulars as to qualifications and experience, to: R. C. McGuire, Vice-Chairman, Port Colborne General Hospital, Port Colborne, Ontario.

Staff Wanted

Science instructor — clinical teachers and Dietitian—immediately. Excellent personnel policies—50 students. Apply—Superintendent, St. Joseph's Hospital, North Bay, Ont.

Registered Record Librarian

R.R.L. required for immediate appointment to head organized Medical Records Department. Attractive salary offered commensurate with experience.

Enquiries stating training, experience and references, as well as recent photograph, invited by A. K. McTaggart, Administrator, Brandon General Hospital.

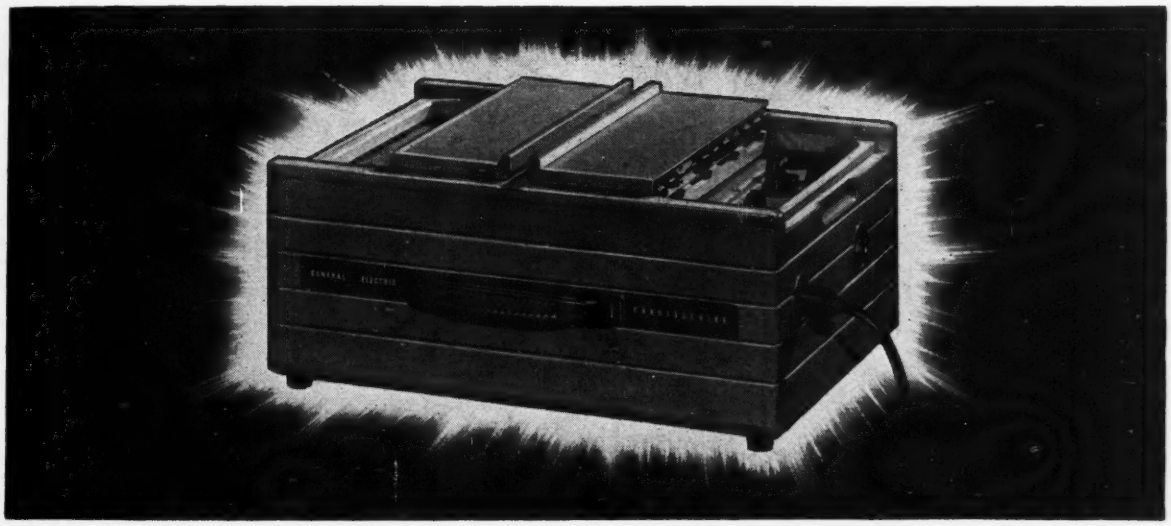
Dietitian Required

Applications are invited for the position of Dietitian of the King Edward VII Memorial Hospital, Bermuda—138 beds. For particulars, write Matron, King Edward VII Memorial Hospital, Bermuda.

(See also page 96)

The line voltage may vary...

But your G-E Cardioscribe® won't notice the difference



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Felting Shrinkage in Washable Woollen Articles

There is no difficulty in removing soil from woollen articles by laundering as wool is one of the easiest fibres to clean — the only problem is to remove the soil without causing felting shrinkage. The felting type of shrinkage is peculiar to wool. However, blankets and other woollen articles can also undergo relaxation shrinkage in laundering due to release of manufacturing strains in the same way as cotton fabrics, if these strains have not been released by a suitable pre-shrinkage treatment. Relaxation shrinkage in a wool article will normally be complete in one washing, but felting shrinkage can increase with repeated washings until eventually the article may be only half its original size and very hard and solid in character.

When a woollen fabric is subjected to mechanical action (i.e., rubbing, flexing, pulling or pounding), while it contains moisture, and especially in the presence of heat, the individual wool fibres intermittently stretch and relax and move relative to one another. Each normal wool fibre has scales on its surface which, like a fish's scales, all point in one direction. Thus, within the fabric, it is easiest for each wool fibre to move in the direction opposite to the free ends of its scales and, once the fibre has moved in that direction, it is hard to pull it back to its original position because of the friction created by the scales. This one-way movement of the individual wool fibres results in the fabric becoming smaller in area but thicker and harder in texture — an effect which is known as felting shrinkage. A felted fabric usually cannot be restored by stretching because the wool fibres have become so tangled and interlocked.

For certain purposes, wool's ability to felt is a valuable property. It enables the manufacture of such fabrics as windproof melton coatings and heavy whipcords, lovely wool broadcloth, doeskin and blankets, as well as such important industrial items as the huge felts used in paper-making. On the other hand, the tendency of woollen articles to undergo felting shrinkage easily during washing is undesirable.

In soft and fluffy fabrics, the wool fibres are less firmly held in position than, for example, in a closely woven worsted suiting; and therefore the fibres are free to move more easily. Thus, wool fabrics of the soft fluffy type, *e.g.*, sweaters and blankets, are very susceptible to felting shrinkage. Furthermore, certain types of wool, *e.g.*, lamb's wool, felt more easily than others. This makes it desirable for manufacturers to choose very carefully the type and grade of wool to be used in washable soft items such as blankets and knitwear.

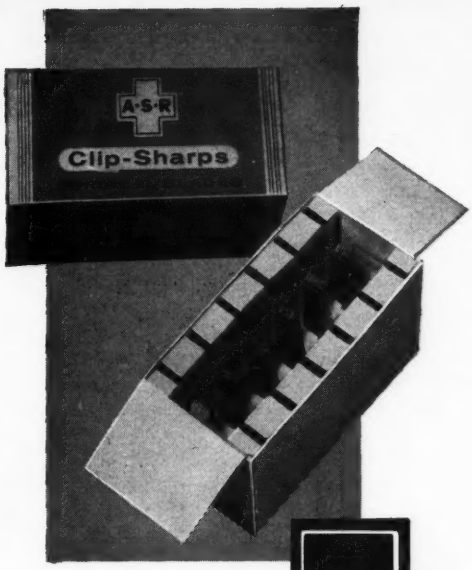
Providing Resistance

The tendency for woollen articles to undergo felting shrinkage during washing can be reduced by the following processes applied during manufacture:

1. By giving the wool or the woollen article a chemical shrinkproofing treatment. Such treatments require very careful control to prevent damage to the wool and resultant lower wear resistance; but they are very effective in decreasing felting shrinkage under normal washing conditions.

2. By blending non-feltable fibres with the wool. The proportion of non-feltable fibre which is necessary for good shrink-resistance depends on the nature of the fibre. Another promising fibre blend consists of approximately 80 per cent wool and 20 per cent orlon. Wool and nylon blends have also been used, *e.g.*, the 80 per cent

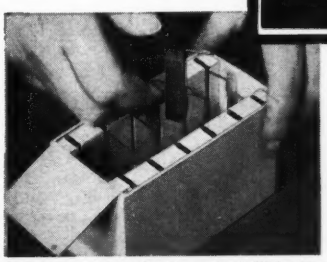
(Concluded on page 92)



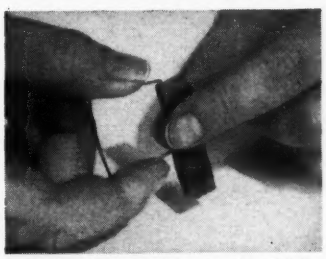
now! quick, easy blade sterilization with

A·S·R Clip-Sharps

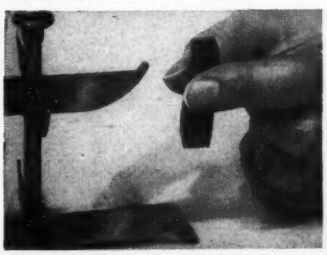
TRADE MARK



Remove cover – hold box in one hand. With other hand lift one wire holder (24 Blades) from box.



Grasp the wire clip between thumb and index finger and squeeze the wire. This releases the tension and enables the blades to be easily removed from the clip.



Holding the blades between thumb and index finger, simply slip them onto the rack. It's quick – and easy!

Clip-Sharps® are convenient wire clips containing 24 unwrapped A.S.R. Command Edge Surgical blades. There are six clips per box, protected by rust inhibiting paper.

Any sterilizing rack and any reliable, non-corrosive sterilizing agent may be used.

If you do not wish to sterilize the entire clip of 24 blades, remove only the required number from the clip and place them on the rack arm.

All A.S.R. Surgical Blades are Sharpometer tested. The A.S.R. Sharpometer, *only* device of its kind, measures the critical edge-fineness of every lot of A.S.R. Surgical Blades. These tests enable A.S.R. to guarantee . . . precise, uniform sharpness and dependability for every single blade!

"**NOW!** For extra convenience, blades are alternated on clips".

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Felting Shrinkage

(Concluded from page 90)

wool and 20 per cent nylon blend in Canadian Army and R.C.A.F. heavy socks. The blending of non-feltable fibres with wool presents certain problems to the manufacturer such as a different handling of the finished fabric as compared with the all-wool counterpart, or a tendency for the non-feltable fibre to rise to the surface of the fabric and pill or shed. Much experimentation may be necessary in some cases to overcome these problems.

3. By the application of certain synthetic resins and other high polymer substances to woollen fabrics. The resin processes have to be carefully controlled in order to ensure their permanence in repeated launderings. — *From an article by C. H. Bayley, M.A., M.A.Sc., and A. S. Tweedie, M.Sc., in the "Technical Bulletin" published by Canadian Research Institute of Launderers and Cleaners.*

Check List for Administrators

Are you aware that:

1. The 1956 Canadian Hospital Directory contains a section on accreditation, including general information, copies of the forms used by the Joint Commission, and a useful bibliography?

2. Several articles have been published on hospital disaster planning in Canada and a short bibliography was published on page 108 of the June, 1956, issue of *The Canadian Hospital*?

3. Each December issue of *The Canadian Hospital* contains an index listing all articles published during that year, both by subject matter and by author?

4. In the June, 1956, issue of *The Canadian Hospital* two Canadian books dealing with legal matters of interest to administrators are reviewed?

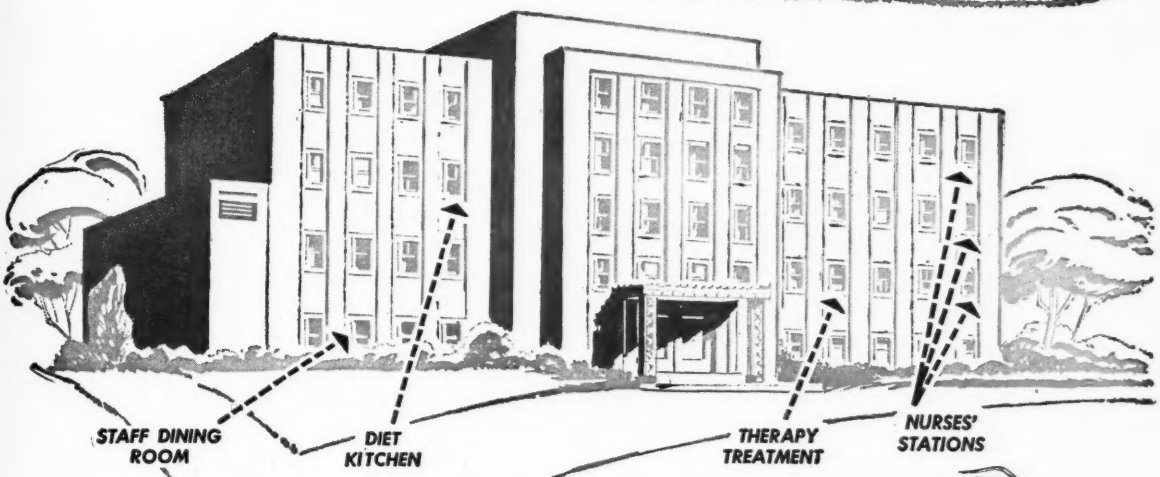
5. C.H.A. book acquisitions to the library during 1955 were published on page 56 of the February, 1956 issue of *The Canadian Hospital*?

6. There *is* a code of ethics for hospitals, and that this was re-published in *The Canadian Hospital* in the March, April and May issues of 1955?

7. The 1955 Canadian Hospital Directory contains a section on library facilities of the Canadian Hospital Association and the procurance of visual aids?

The Delphic oracle said that I was the wisest of all the Greeks. It is because that I alone, of all the Greeks, know that I know nothing. — *Socrates.*

SCOTSMAN ICE MACHINES
on every floor!



Save time . . . Save work . . . Save Money

Whatever your ice needs — there is a Scotsman Automatic Super Flaker or Super Cuber to meet every one. You can locate a Scotsman Ice Machine at stations on every hospital floor. Low priced, efficient Super Cubers will save time, work and money by providing solid, sparkling, sanitary Super Cubes right where they are needed. No need to "haul" ice from a remote central plant.

When flaked ice is needed for cold packs or therapy the Scotsman Super Flaker supplies dry, hard, free-flowing crushed ice. This superb Scotsman ice is made quietly without grinders, choppers or knives, using a mechanism which is the most dependable, yet simplest, ever designed. Again, simply locate a machine where ice is needed.

Warm weather brings heavy ice demands. Now is the time to write for complete information and facts about SCOTSMAN — America's only complete line of ice machines designed and priced for every hospital need.

For kitchen and staff dining rooms Scotsman Super Cubers are available in sizes which produce from 110 to 500 pounds of Super Cubes daily. Exclusive Scotsman "Cycle-Matic" control guarantees perfect cubes every harvest — cubes that are actually purer than the water from which they are made! All Scotsman Ice Machines operate on standard electrical connections.

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The Canadian Hospital is published monthly by the Canadian Hospital Association as its official journal devoted to the hospital field across Canada.

The subscription rate in Canada,. U.S.A., and Gt. Britain is $3.00 per year. The rate for each additional subscription to hospitals or organizations having a regular subscription (and personal subscription for individuals directly associated with them) is $1.50 per year. The rate to other countries is $3.50 per year. Single copies, when available, are supplied at 50c each.

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For Trustees Only

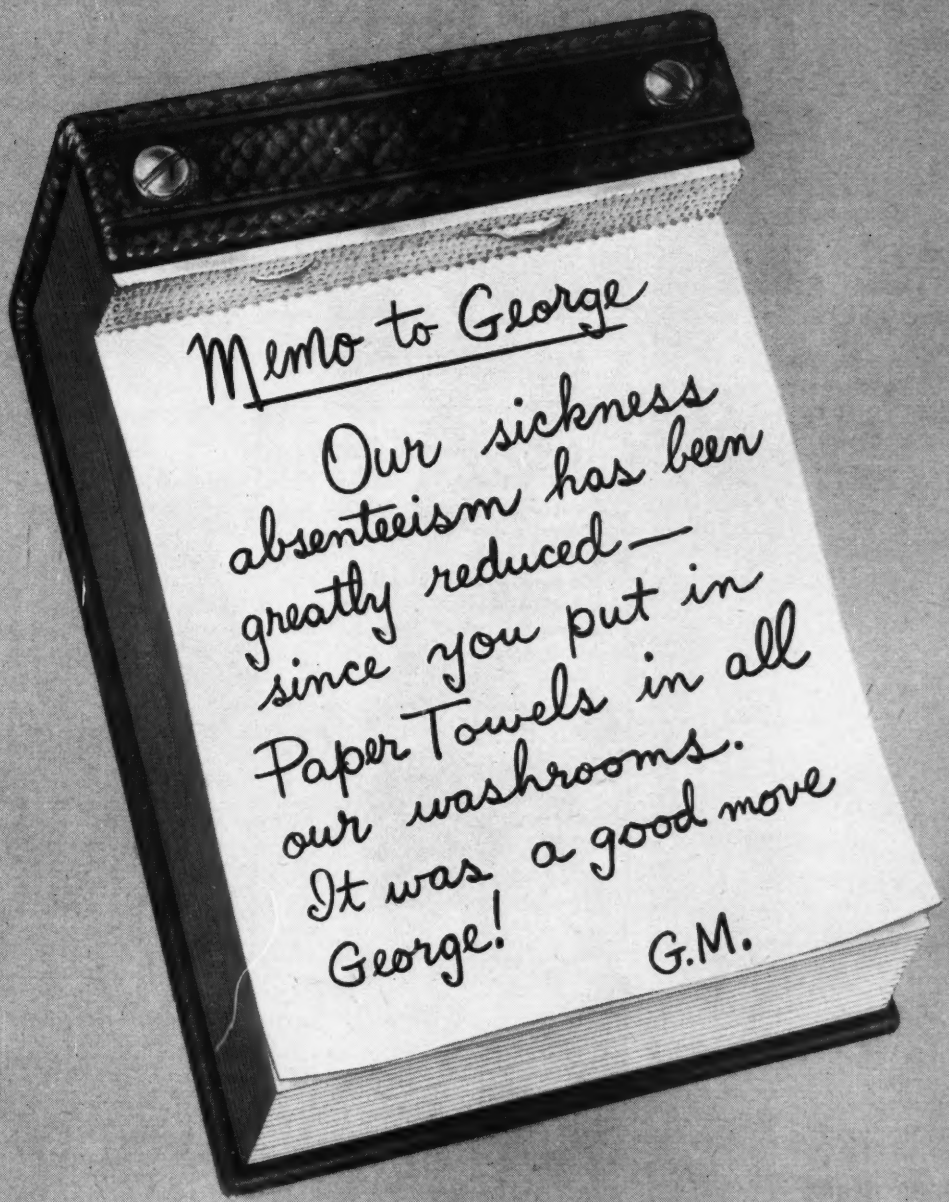
(Concluded from page 52)

statement for the first time when they arrive at the board meeting. Some hospitals mail the statement to the trustees in advance so that they have adequate time to study it before they come to the meeting.

It goes without saying that the trustee should also see bulletins put out by his provincial association.

There are many ways of keeping the trustees thoroughly informed and the suggestions I have made certainly do not exhaust the list. For example, the Rochester Regional Hospital Council has held trustee institutes devoted to specific subjects, such as medical staff organization, and these have been very successful. One hospital keeps potential trustees informed by sending a bulletin to members of the hospital society.

Each hospital should search for a procedure which will meet its own requirements. It is impossible to develop a plan which will apply precisely to all hospitals. Whatever the variation, the important thing is that there should be a definite program. The trustee has a difficult and important task. To perform it well, he will need as much of the relevant information as he can study in the time he is able to devote to hospital affairs. ●



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For Moncton Hospital, Moncton, N.B. (210 beds). Five dietitians on staff. Straight 8-hour day. Please apply to Chief Dietitian.

Assistant Medical Records Librarian Wanted

For 400 bed hospital experienced in the use of Standard Nomenclature. Salary commensurate with experience. Applications should state qualifications, experience and personal data and be addressed to: Administrator, The St. Catharines General Hospital, St. Catharines, Ont.

Dietitians Wanted

To head Dietetic Department of 275-bed general hospital. Attractive salary, good personnel policies and working conditions. Applications will also be considered for additional junior dietitian to augment present service. Apply—Administrator, The General Hospital of Port Arthur, Port Arthur, Ontario.

Queensway General Hospital
Toronto 14, Ont.

Is accepting applications for employment in all nursing Departments
Supervisors — Head Nurses
General Staff — Nursing Assistants — Orderlies — Ward Secretaries

Newest hospital in Toronto, situated on The Queen Elizabeth Way, 12 miles from downtown Toronto. Attractive residence facilities available in the new apartment type residence. Hospital scheduled to open August 1, 1956. Excellent salaries and personnel policies. Apply Director of Nursing, Queensway General Hospital, Toronto 14, Ont.

Executive Housekeeper Wanted

Applications are invited for the position of Executive Housekeeper in a large Eastern Ontario hospital. Please give particulars regarding age, qualifications, past experience and salary expected to Box 7140, The Canadian Hospital, 57 Bloor St. W., Toronto.

Administrator Available

Administrator—Male—18 years' experience including Fund Raising and Hospital Construction programs—Reply to Box No. 705M, The Canadian Hospital, 57 Bloor St. W., Toronto.

Obstetrical Instructor

To take charge of teaching programme in the Obstetrical Department. Applicant should have at least 1 year University preparation in the field of Maternal and Child Health.

Address communications to:

Director of Nursing
Kingston General Hospital
Kingston, Ontario

Administrative Personnel Placement Service

Mary A. Johnson Associates welcomes inquiries from Hospital Trustees and Administrators for assistance in locating Administrative and Department Head Level Personnel for Hospital and Medical Group positions.

Dr. Johnson is trained and experienced in Hospital Administration as well as Personnel Management and is available for Consultation of Personnel needs.

Our files contain many well qualified personnel as well as interesting openings.

We pride ourselves on careful screening of all our clients and thorough investigation of openings. Our aim: to match the applicant and the specific position.

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Director of Nursing Education Required

Prince County Hospital, Summerside, P.E.I. requests applications for position of Director of Nursing Education and Nursing Service. A fully accredited voluntary general hospital, 116 beds, and School of Nursing, 36 students. To act as assistant to administrator, teach science subjects and plan curriculum. Degree desirable but not a requirement. Several years supervising and/or instructor experience is required in lieu of degree. Salary to be mutually agreed upon. Private living quarters in new residence. Assistant Instructress and diploma supervisors to assist in clinical teaching. Apply to: Administrator, Prince County Hospital, Summerside, P.E.I.

DIETITIANS

The Provincial Mental Health Services of British Columbia require qualified Dietitians to take charge of dietary service in various kitchen units at Essondale, near New Westminster, B.C. (Population 31,000). Dietary Dept. reorganized; 40-hour week; generous holiday and sick leave, superannuation plan, good personnel policies, ample recreational facilities. May live in. Salary $250.-$305. per month. Apply Personnel Officer, B.C. Civil Service Commission, Essondale, B.C.

(See also page 88)

Here's a new concept in automatic bookkeeping. The National Class "32" soon pays for itself—and pays repeated dividends on your initial investment. It provides new ease of operation and operator training—offers new speed of posting to keep pace with the tempo and volume of modern business.

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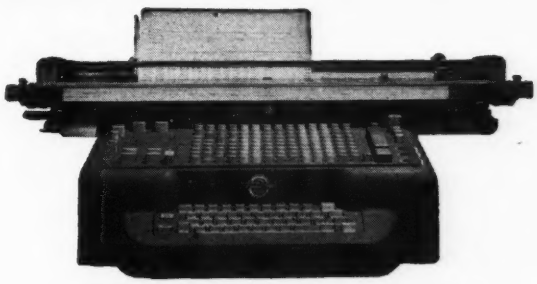

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Grants from Life Insurance Companies

Grants to support a number of public health and medical research projects have been awarded by the life insurance companies doing business in Canada, through the standing Committee on Public Health of the Canadian Life Insurance Officers Association.

One of the major grants is to the College of General Practice of Canada. It is a renewal grant and will be used in connection with the survey of general practice that the College is conducting across the nation.

Another renewal grant is to the University of Toronto's division of dental research. Under the direction of Dr. John B. MacDonald, this research seeks to acquire knowledge that will lead to the prevention of dental disease. Studies dealing with tooth decay, diseases of the gums and malformation of jaws and teeth are being conducted.

The Canadian Tuberculosis Association also receives a grant for the continuation of the health educational program conducted by the Newfoundland Tuberculosis Association.

Financial assistance is extended to the Canadian Diabetic Association to assist in its program of organizing additional branches and extending its educational services; and to the Canadian Highway Safety Conference to promote its program to reduce highway accidents in Canada.

In the field of medical research, the Association announces grants to the Research Institute of the Hospital for Sick Children of Toronto, Queen's University Medical School, and to the Montreal General Hospital.

At the Hospital for Sick Children, the grant has been made to the Research Institute to complete its study of virus infections by tissue culture methods. Diseases being examined include poliomyelitis, Coxsackie disease, mumps, aseptic meningitis, skin diseases, German measles, and chicken pox. This study is under the direction of the Institute's Director, Dr. A. J. Rhodes. The new tissue culture techniques are being used and are carried out in the medical wards and the virus research department of the hospital.

At Queen's University a team composed of Doctors Sergio Bencosme, David Rosen and D. Laurence Wilson is doing research into the vascular complications of diabetes mellitus.

The grant to the Montreal General Hospital is to support a combined clinical and pathological study of strokes. This study is to be conducted by Dr. D. A. Howell in the neurological and pathological departments of the hospital under the direction of Doctors J. Pritchard and H. Elliott.

The United States Public Health Service reports that polio cases in that country continue to decline. Total for the year is now 1,632 cases in contrast to 2,046 this time last year.

Hamilton Cancer Hostel

A new $50,000 hostel has been opened by the Hamilton, Ont., unit of the Canadian Cancer Society to accommodate out-of-town patients attending the local cancer clinic. A. R. Winnett of Toronto, president of the Ontario Division of the Canadian Cancer Society, announced that a policy has been established by which the operation of these hostels, once they had been set up by local units of the Cancer Society, would be turned over to the Cancer Foundation, which is more directly concerned with the medical treatment of patients.

When I'm getting ready to reason with a man, I spend one third of my time thinking about myself and what I am going to say — and two thirds of my time about him and what he is going to say. — *Abraham Lincoln.*

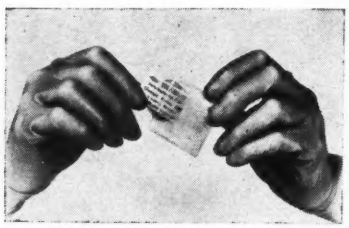
News Released by Hospital Supply Houses

By C.A.E.

Davis & Geck, Surgilar Sterile Pack

Surgilar* Sterile Pack, a revolutionary development in the packaging of sterile surgical gut sutures by Davis & Geck, Danbury, Connecticut, is rapidly approaching full-scale production in their modern Danbury laboratories.

Surgilar Sterile Pack eliminates the hazards of breaking glass tubes in the operating room by packaging 54 ins. of heat-sterilized surgical gut in a sealed transparent plastic envelope that is, in turn, enclosed in a glassine envelope. The strands of sterile surgical gut are doubled to 27-inch lengths, coiled and placed in the fold of an identifying label. The size of the sterile plastic envelope allows the gut to coil naturally — without constriction. This feature insures less handling, eliminates kinks and bends and delivers a stronger, more flexible strand of gut to the surgeon.



A wide-mouthed jar, (½ the size of glass tube jars) filled with a sterilizing solution, holds 36 double envelopes. Forceps can remove up to 8 envelopes at one time, using routine aseptic technique. The suture nurse cuts through the tops of both envelopes with one snip of the scissors and readily grasps the gut coil by its label. Unused envelopes may be returned to the Surgilar jar solution with sterile forceps after the removal of the protective outer envelope. The outer envelope protects the cleanliness of the plastic envelope and eliminates washing. The Surgilar solution will restore the sterility of the exterior of the plastic envelope in two hours.

Surgilar Sterile Pack, hospital-tested by Davis & Geck and designed for improved patient care, in addition to eliminating glass tubes and delivering a loose coil of strong flexible gut free from kinks, also cuts preparation time by 1/3, decreases suture stocks and saves over 50 per cent storage space. (*Trademark)

National Silicates Building at Valleyfield, P.Q.

National Silicates Limited, Toronto, manufacturers of soluble silicates, has announced that the construction of its new Valleyfield plant, near Montreal, is proceeding on schedule. It is located East of Fabre Street in Valleyfield and has a direct siding with the Canadian National Railroad.

National Silicates Limited was formed in 1931 by the Philadelphia Quartz Co., U.S. silicate manufacturers since 1860, with G. F. Sterne & Sons, Limited, Brantford, Ont., who were Canadian distributors of the Quartz Company silicates. The Toronto plant began producing silicates in 1933. Its facilities have since been expanded to serve the requirements of their trade. Valleyfield plant will be equipped to supply the needs of industry in the Montreal-Valleyfield area and other points in the Province of Quebec and the Maritimes.

General headquarters for National Silicates Limited are located in New Toronto at the corner of Kipling and Horner Avenue.

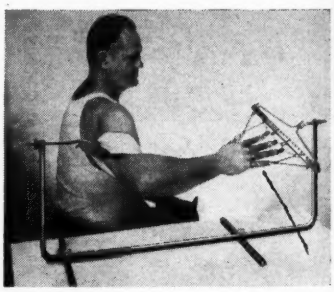
Lily Denture Cup

Just introduced, and the first paper cup of its kind to be made in Canada, is this Lily Denture Cup. Attractively finished in green, the Lily Denture Cup has 8 oz. capacity for cleansing solution in which dentures can be placed overnight or for longer periods.

Identification is easy with space provided for patient's name, bed number and room. Notations can also be made on the tight-fitting lid. Wide use of this cup is expected in hospitals.

New DePuy Forearm Reduction Frame

A new frame designed to meet the need for an inexpensive, easy to use apparatus for the reduction of forearm fractures has been announced by DePuy Manufacturing Co., Inc., Warsaw, Indiana. The simplicity of the new Forearm Reduction Frame permits the surgeon to reduce the arm and apply the cast without the aid of an assistant. The frame is designed so that the cast can be applied while the arm is in traction. Used in a horizontal plane, traction and counter-traction can be applied. A simple adjustment enables the arm to be reduced and the cast applied in a vertical plane if the surgeon prefers.



The hand traction assembly can be quickly and easily applied, and the retaining sleeve securely anchors the upper arm. Wing nut adjustments provide for just the right amount of traction. The metal framework is constructed so that the entire unit can be folded flat for storage. The complete unit is sold as Item No. 669. Hand Traction Assembly is available separately as Item No. 669A.

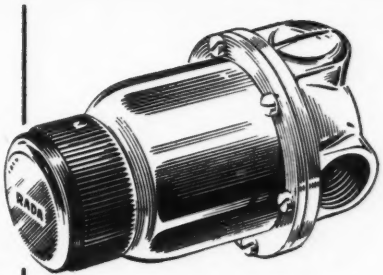
(Concluded on page 102)

The coil that makes the shower a joy

Some bare facts

A shower is the best bath in the world. The skin glows in the surge and the rush of the pin-point spray. The bather screws up her face and squeaks with delight under the swift attack. But a shower must be under the control of a thermostat or it may turn a little too frisky. A Rada thermostatic valve will keep the temperature steady. It will iron out the hot or take the kick out of the cold. Rada thermostatic showers save heat, save water, save piping, and make the shower bath a delight without alloy.

Write for literature and full information to any of the addresses given below.



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75 Upper Water Street
Tel. 3-6995

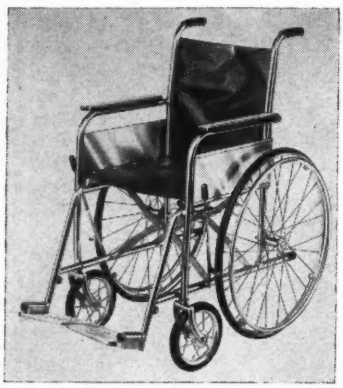
Across the Desk

(Concluded from page 100)

Everest & Jennings New Hollywood Wheel Chair

The introduction of a completely new line of "Hollywood" folding wheel chairs is announced by Everest & Jennings, Inc.

New streamlined production techniques have enabled the company to add many of their higher-priced chair features to the "Hollywood" line without removing it from the medium price field.



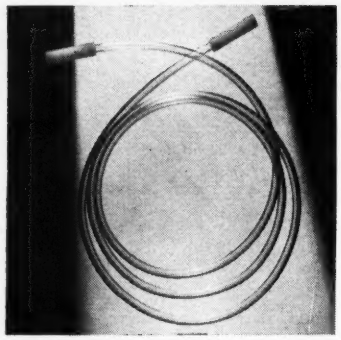
The new Hollywood chairs are strengthened by all welded construction and finished with improved chrome plating for longer lasting beauty. Reassuring slight rearward tilt of seat and adjustable footrests now provide greater patient comfort. Engineered for easier handling, the new chairs require only finger-tip pressure to fold. (Folded width is only 9¾ ins.)

A feature of special interest to hospitals is that, in either 5-in. or 8-in. caster series, standard foot-rests are interchangeable with elevating leg-rests. Unique snap locks permit conversion without tools. Because footrest assemblies are so easy to snap on and off, Hollywood wheel chairs are much easier to carry in car and to store in smaller places.

Two New Pharmaseal Plastic Tubes

Two transparent plastic connecting tubes for suction apparatus are being introduced by Pharmaseal Laboratories, Glendale, California. One tube, the K-65, is 1½ feet long and is designed for connecting an aspirating bottle to a suction source. The other tube, the K-66, is six feet long. It serves as a connection between a suction catheter and an aspirating bottle. Both tubes are equipped with female plastic adapters on each end.

The manufacturer claims that these plastic connecting tubes are kink-resistant, lightweight, easier to clean, and

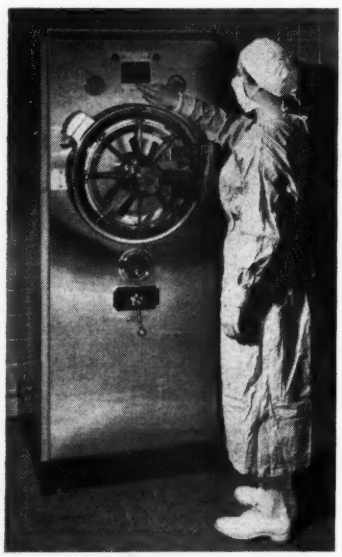


will not retain odours. They are not damaged by heat, oxidation, or chemical action and give longer service than tubes made of other materials. Transparency permits clear observation of aspirate and facilitates locating and dislodging of obstructions.

Push Button Instrument Washer-Sterilizer

A push-button Instrument Washer-Sterilizer is announced by the Wilmot Castle Company.

From the pressing of a single control button, every phase of the washing-sterilizing cycle is electromatically con-



trolled by a motor-driven valve selector. In one operation instruments directly from a surgical case are pressure rinsed, soaked, scoured in hot detergent bath, sterilized in superheated water at 270 degrees F., and flash-dried for immediate re-use or storage. Entire cycle takes approximately 15 minutes, during which time operator is free for other routine.

Known as the Castle No. 200 Automatic, the unit includes a new dual-lock safety door, which is locked throughout entire cycle, and cannot be accidentally opened at low pressures. Pressurized rinsing action of overhead cold water fill, and newly devised scouring action are other exclusive features, according to the manufacturer.

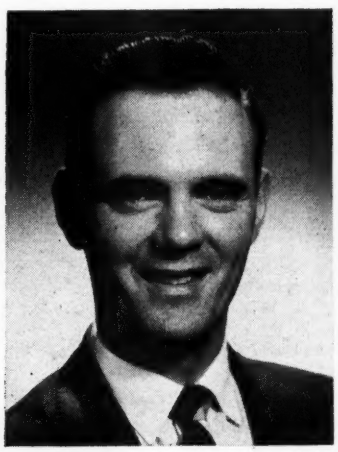
Write Wilmot Castle Company, 1776 E. Henrietta Rd., Rochester 2, N.Y. for complete details.

G. A. Hardie & Co. Appointment

G. A. Hardie & Co. Limited, announce the appointment of Maurice O. Edwards, London, Ontario, to the sales staff. He will cover the Western Ontario territory.

Mr. Edwards has had an excellent record with a well established company for a number of years. Supplying Super-Weave Textiles to the institutional, industrial and laundry fields, Mr. Edwards will continue the service for which the company is renowned.

R. C. (Reg) Harriss resigns July 15th., from the position of sales manager of the above company. Mr. Harriss has purchased a modern service station and self-serve general store eight miles north of Guelph on No. 24 highway, where he will be located by the middle of July.



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